

**GROUP  
DISABILITY  
INCOME  
BENEFITS**

**INSURANCE INFORMATION**

**AMERICAN FIDELITY**  
a different opinion 

[americanfidelity.com](http://americanfidelity.com)

G113-10  
014916-CSE  
CA



January 22, 2026

Dear Valued Customer,

Thank you for giving American Fidelity the opportunity to help serve your insurance needs. We appreciate having you as a customer and applaud your decision to protect yourself and your family with this coverage.

This is your new Group Disability Income Benefit Certificate. Please review the documents carefully. Feel free to call us at 800-662-1113 if you have any questions or need assistance. We also strongly encourage you to create an online account at [americanfidelity.com](http://americanfidelity.com), where you can file claims, upload documentation, find policy information and more. An online account also allows you to easily file for benefits that may be eligible for quicker processing. Visit [americanfidelity.com/afquickclaims](http://americanfidelity.com/afquickclaims) for more information.

**Notice for insureds living in a community property state (Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin):**

**If you have designated a beneficiary other than your spouse, we may be required to pay a portion of the proceeds to your spouse at the time of your death, unless your spouse has signed a spousal waiver form. To obtain a spousal waiver form, please visit [americanfidelity.com/forms](http://americanfidelity.com/forms) or call 800-662-1113.**

Sincerely,

President and Chief Operating Officer

**We are here to serve you . . .**

As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If you have any questions regarding a claim, please call Benefits at 800-662-1113. If you have any other questions regarding your coverage, you may reach our Customer Service department by contacting us at:

**American Fidelity Assurance Company  
9000 Cameron Parkway  
Oklahoma City, Oklahoma 73114  
Toll Free: 800-662-1113**

If your policy or certificate was delivered by an agent or broker, you may contact your agent or broker for assistance.

**If you are not satisfied . . .**

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. The California Department of Insurance should be contacted only after you have contacted American Fidelity Assurance Company or its representative for a satisfactory solution.

To contact the Department, write or call:

**Department of Insurance  
Consumer Services Division  
300 South Spring Street  
Los Angeles, California 90013**

**Consumer Hotline: 1-800-927-HELP**

**(THIS FORM IS NOT A PART OF YOUR CONTRACT.)**



9000 Cameron Parkway Oklahoma City, Oklahoma 73114

### CERTIFICATE OF INSURANCE

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:

- (1) You are eligible for the insurance (see ELIGIBILITY on Schedule of Benefits);
- (2) You are on Active Employment on the date it is to take effect; and
- (3) You become insured and remain insured in accordance with all the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.

President and Chief Operating Officer

Secretary

### NON-PARTICIPATING GROUP DISABILITY INCOME INSURANCE CERTIFICATE

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

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### Schedule of Benefits

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**SCHEDULE OF BENEFITS**  
**PLAN: 014916-CSE**

**POLICYHOLDER:** BANK OF OKLAHOMA, N.A., TRUSTEE FOR THE NATIONAL SCHOOL EMPLOYEES INSURANCE TRUST

**POLICY NUMBER:** G113-10

**CERTIFICATE EFFECTIVE DATE:** Please refer to your individual application or enrollment form, if any.

**ELIGIBILITY:** All CSEA members working 10 or more hours per week.

**CLASS 1:** On the date You become Disabled, You have 5 or more years of credited service under the California State Teachers Retirement System (STRS) or Public Employees Retirement System (PERS).

**CLASS 2:** On the date You become Disabled, You participate in but have less than 5 years of credited service under the California State Teachers Retirement System (STRS) or Public Employees Retirement System (PERS).

**ACCIDENTAL DEATH  
AND DISMEMBERMENT**

**BENEFIT:** \$50,000.00

**SHORT TERM DISABILITY INCOME BENEFITS**

**Class 1 and Class 2 Insureds**

**DISABILITY BENEFIT:**

- A. While eligible to receive Fully Paid Sick Leave: \$50.00 for each Regular Day of Required Attendance missed during disability or \$100.00 while confined to a Hospital for at least 18 continuous hours in duration.
- B. While not eligible to receive Fully Paid Sick Leave: 80% of the Regular Daily Contract Salary less any Deductible Sources of Income, for each Regular Day of Required Attendance missed during Disability. The Minimum Disability Benefit will be 25% of the Regular Daily Contract Salary or \$30.00, whichever is greater.

Refer to Section 1 of the Certificate for the definition of Regular Daily Contract Salary.

**MAXIMUM COVERED SALARY:** \$300,000.00

**MAXIMUM DISABILITY PERIOD:**

Accidental Injury: 2 Benefit Years  
Sickness: 2 Benefit Years

Mental Illness Benefit  
Period: 6 months

Alcoholism & Drug  
Addiction Benefit  
Period: 14 days

Special Conditions  
Period: 2 years not to exceed the Maximum Disability Period

**SURVIVOR BENEFIT:** The dollar amount of the daily Disability Benefit being paid to You under this plan at the date of death. This benefit will be paid to the end of Your Maximum Disability Period, or 100 Regular Days of Required Attendance, whichever is less.

**ELIMINATION PERIOD:**

Accidental Injury: 7 consecutive Regular Days of Required Attendance during Disability.  
Sickness: 7 consecutive Regular Days of Required Attendance during Disability.

**SUMMER BENEFIT:** \$200.00 per month for Disability commencing and satisfying the Elimination Period prior to the end of the regular school year.

Under no circumstances, will Your benefit be calculated on an amount greater than the income bracket for which You have paid premium.

**LONG TERM DISABILITY INCOME BENEFIT**

**ELIMINATION PERIOD:** The expiration of the period for which Short Term Disability Income benefits are provided.

**CLASS 1 Insureds:** 10% of the Regular Monthly Contract Salary up to a Maximum Covered Salary of \$300,000.00. The Disability Benefit, together with all Deductible Sources of Income, shall not exceed 80% of Your Regular Monthly Contract Salary.

**CLASS 2 Insureds:** 66 2/3% of the Regular Monthly Contract Salary up to a Maximum Covered Salary of \$300,000.00 less any Deductible Sources of Income.

**MINIMUM DISABILITY BENEFIT:**

**CLASS 1 Insureds:** \$100.00 per month

**CLASS 2 Insureds:** 10% of Your Disability Benefit or \$100.00 whichever is greater.

Refer to Section 1 of the Certificate for the definition of Regular Monthly Contract Salary.

**MAXIMUM DISABILITY PERIOD:**

**Accidental Injury or Sickness:**

**Accidental Injury and/or Sickness:**

<u>Age</u>	<u>Maximum Benefit Period</u>
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
Age 60	60 months, or to SSNRA*, whichever is greater
Age 61	48 months, or to SSNRA*, whichever is greater
Age 62	42 months, or to SSNRA*, whichever is greater
Age 63	36 months, or to SSNRA*, whichever is greater
Age 64	30 months, or to SSNRA*, whichever is greater
Age 65	24 months, or to SSNRA*, whichever is greater
Age 66	21 months, or to SSNRA*, whichever is greater
Age 67	18 months, or to SSNRA*, whichever is greater
Age 68	15 months, or to SSNRA*, whichever is greater
Age 69 or older	12 months, or to SSNRA*, whichever is greater

\*Age at which You are entitled to unreduced Social Security benefits based on current Social Security Amendments.

Long Term Disability Income Benefits are not payable for Disability caused by mental illness, alcoholism or drug addiction, unless You are Hospital confined.

Long Term Disability Income Benefits are not payable for Disability caused by Special Conditions.

Under no circumstances, will Your benefit be calculated on an amount greater than the income bracket for which You have paid premium.

## SECTION 1 DEFINITIONS

**ACCIDENTAL INJURY** means Accidental bodily Injury(ies) sustained by You which:

- (a) is (are) independent of disease or bodily infirmity or any other cause; and
- (b) takes place while Your coverage is in force.

**ACTIVE EMPLOYMENT** means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not Disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

**BENEFIT YEAR** means a period equal to the number of Regular Days of Required Attendance specified in Your contract for the school year in which the Period of Disability began. For purposes of these benefits, the Benefit Year begins on the day following the expiration of Fully Paid Sick Leave. Restoration of Fully Paid Sick Leave after its initial expiration will extend the Benefit Year by the number of additional days of Fully Paid Sick Leave.

**CERTIFICATE** means the individual Certificate issued to You. It describes Your coverage under the Policy.

**DISABILITY (or Disabled)** for the first two Benefit Years that disability benefits are paid means that You are unable to perform with reasonable continuity the material and substantial duties of Your Regular Occupation in the usual and customary way. After that, Disability means You are unable to perform with reasonable continuity the material and substantial duties of any Gainful Occupation that You reasonably could be expected to perform satisfactorily in light of Your age, education, training, experience, station in life; and physical and mental capacity.

**EFFECTIVE DATE** means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

**ELIMINATION PERIOD** means that period of time, which starts after Your Effective Date of coverage, during which:

- (a) You are Disabled; and
- (b) no Disability Benefits are payable.

**EMPLOYER** means the individual, company, corporation, or governmental entity where You are on Active Employment and includes any division, subsidiary, or affiliated company named in the Policy.

**FULLY PAID SICK LEAVE** means the total number of days of sick leave, catastrophic leave or similar pay to which You are entitled. Receipt of donated sick leave will be considered fully paid sick leave.

**GAINFUL OCCUPATION** means an occupation that is or can be expected to provide You with an income of at least 60% of Your Regular Monthly Contract Salary.

**HOSPITAL** means a licensed institution which:

- (a) has on its premises:
  - (1) laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
  - (2) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
  - (3) 24-hour-a-day nursing service by graduate registered nurses; and
  - (4) the patient's written history and medical records;
- or:
- (b) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall not include an institution used by You as:

- (a) a place for rehabilitation;
- (b) a place for rest or for the aged;
- (c) a nursing or convalescent home;
- (d) a long term nursing unit or geriatrics ward; or
- (e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**INSURED** means a person whose coverage has been applied for, approved, and is in force under the terms of the Policy.

**PENSION PLAN** means a plan which provides retirement benefits to You and is not funded wholly by Your contributions. It includes a retirement plan which is part of any federal, state, county, municipal or association retirement system which You are eligible for as a result of employment with the Policyholder. It does not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), a tax-sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

**PHYSICIAN** means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your sickness or Accidental Injury; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, an employee of the Employer, anyone related to You by blood or marriage, or anyone living in Your household.

**POLICY** means the Policy issued to the Policyholder which covers You.

**POLICYHOLDER** means the association, Employer, or trustee who holds the Policy.

**PRE-EXISTING CONDITION** means a disease, Accidental Injury, Sickness, physical condition or mental illness for which You have experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before Your Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accidental Injury, Sickness, physical condition or mental illness.

**PUBLIC EMPLOYEES RETIREMENT SYSTEM** means the applicable provision of the Education Code of the state of California which relates to the Public Employees Retirement System.

**REGULAR AND APPROPRIATE CARE** means:

- (a) You personally visit a Physician as frequently as medically required, according to standard medical practice, to effectively manage and treat Your disabling condition(s); and
- (b) You are receiving appropriate treatment and care for Your disabling condition(s), which conforms with standard medical practice, by a Physician whose specialty or experience is the most appropriate for such disabling condition(s), according to standard medical practice.

**REGULAR DAILY CONTRACT SALARY** means the gross salary payable to You for the regular school year, divided by the number of Regular Days of Required Attendance specified by the District for the contract year during which disability begins up to the amount for which premium is paid. It may also include other equivalent compensation arrangements for the regular school year as mutually agreed upon by the Policyholder and Us. It excludes any additional compensation, including but not limited to, overtime pay, weekend or summer school work compensation, bonuses or district-funded fringe benefits.

**REGULAR MONTHLY CONTRACT SALARY** means the gross salary payable to You for the regular school year, up to the amount for which premium is paid, divided by twelve (12). It may also include other equivalent compensation arrangements for the regular school year as mutually agreed upon by the Policyholder and Us. It excludes any additional compensation, including but not limited to, overtime pay, weekend or summer school work compensation, bonuses or district-funded fringe benefits.

**REGULAR DAY OF REQUIRED ATTENDANCE** means any day of teacher attendance required by regulations of the employing unit.

**REGULAR OCCUPATION** means the occupation You are routinely performing when your Disability begins. We will look at Your occupation as it is normally performed in the national economy, rather than how the work tasks are performed for a specific Employer or at a specific location.

**REHABILITATIVE EMPLOYMENT** means any job for gain or profit for which You are reasonably fitted by education, training or experience.

**SCHEDULE OF BENEFITS (or Schedule)** means the benefit schedule set forth in the Policy or Certificate.

**SCHEDULED VACATION PERIOD** means any vacation period, other than a leave of absence, which is at least 2, but less than 14 consecutive weeks in duration.

**SICKNESS** means a disease or illness (including pregnancy). Disability must begin while this coverage is in force.

**STATE TEACHERS RETIREMENT SYSTEM** means the applicable provision of the Education Code of the state of California which relates to the State Teachers Retirement System.

**SUBSCRIBING UNIT** means an Employer or an Employer who is a member of an association who has elected in writing to participate in the coverage under the Policy.

**SUMMER BENEFIT** means a benefit payable during the summer months (those months not included under contract for the regular school year) for Disability commencing and satisfying the Elimination Period prior to the end of the regular school year.

## **SECTION 2** **ELIGIBILITY AND EFFECTIVE DATE**

### **ELIGIBILITY**

You are in an eligible class if You:

- (a) are a full-time employee of one of the following employers:
  - (1) any division of the California Public Schools;
  - (2) a State College;
  - (3) the State University; or
  - (4) any higher educational institution in California; and
- (b) are a current member of the Policyholder; and
- (c) are a member of a qualified Subscribing Unit under the Plan; and
- (d) are a contracted employee with a Regular Annual Contract Salary, or the equivalent thereof agreed upon by the Policyholder and Us, and routinely works at least 15 hours or more per week away from home for Your employer.

You are not eligible for coverage if You are a student member.

If You are in the eligible class, You become eligible for coverage on the later of:

- (a) the effective date of the Subscribing Unit's Plan; or
- (b) the date You enter or return to the eligible class.

If You are a full-time employee or member of more than one employer and/or a member of more than one qualified Subscribing Unit which offers salary protection coverage:

- (a) Eligibility requirements, premiums and benefits under each employer's plan will be based only on Your work schedule at, and Your income from, that employer.
- (b) If You are in the eligible class for coverage through both employers, the total amount of benefits You receive under both plans will be no different than if Your entire salary and work schedule had been received through one employer.

### **EFFECTIVE DATE**

Your insurance will take effect on the Effective Date of the Policy if You:

- (a) apply in writing on or before said Effective Date;
- (b) meet Our underwriting rules; and
- (c) are on Active Employment, as defined in Section 1.

After the Effective Date of the Policy, Your insurance will take effect on the requested Effective Date or the first of the month following the date We approve the written application (subject to Our underwriting rules), whichever is later, provided You are on Active Employment and premium has been paid.

Employees/members who want to apply for this insurance must apply for coverage that will provide benefits according to the applicable class set out in the Policyholder's application.

If You are not on Active Employment due to an Accidental Injury or Sickness when Your coverage would otherwise take effect, it will take effect after the date You go back to Active Employment for at least 5 consecutive Regular Days of Required Attendance.

Any changes in the Disability benefit or Elimination Period will take effect on the requested Effective Date of such changes or the first of the month following the date We approve the written application (subject to Our underwriting rules), whichever is later, provided premium has been paid and provided You are on Active Employment.

Any change in the Policy provisions will apply only to covered periods of Disability which begin after the Effective Date of such changes, subject to all the provisions of the Policy.

### SECTION 3 DISABILITY BENEFITS

Disability benefits will be provided if You furnish Proof of Loss that You are Disabled and under the Regular and Appropriate Care of a Physician. Disability must:

- (a) be due to a covered Accidental Injury or Sickness; and
- (b) begin while Your coverage is in force.

Disability benefits will be provided for each period You remain Disabled due to a covered Disability and under the Regular and Appropriate Care of a Physician which continues beyond the Elimination Period.

No Disability benefit will be provided for any period in which You are not under the Regular and Appropriate Care of a Physician.

Disability benefits will be provided for only one Disability when:

- (a) more than one Disability exists at the same time; or
- (b) a Disability results from two or more causes.

If any monthly benefit is to be paid for less than a full month, the amount of benefit will be reduced pro rata on the basis that one day's benefit equals one-thirtieth (1/30) the monthly benefit.

Disability will be deemed to have commenced on the date You first receive personal treatment from a Physician following continuous cessation of work.

**SUCCESSIVE DISABILITIES** are those Disabilities which result from the same or related causes for which benefits are payable under the Policy and will be considered one period of Disability unless the Disabilities are separated by Your return to:

- (a) Active Employment; or
- (b) any other Gainful Occupation,

for at least 66 Consecutive Regular Days of Required Attendance. A Disability due to a different or unrelated cause will be considered a new period of Disability.

Any Disability which begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Policy.

## **SHORT TERM DISABILITY INCOME BENEFITS IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

### **Class 1 and Class 2 Insured**

Your Disability benefit will be calculated as follows:

For the first two Benefit Years, Disability benefits are provided, the Disability benefit will be:

- (a) \$50.00 for each Regular Day of Required Attendance missed during Disability; while eligible to receive Fully Paid Sick Leave;
- (b) 80% of the Regular Daily Contract Salary up to a Maximum Salary to be covered of \$300,000.00 less any Deductible Sources of income, for each Regular Day of Required Attendance missed during Disability, while not eligible to receive Fully Paid Sick Leave.

## **LONG TERM DISABILITY INCOME BENEFITS IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING**

Benefits will start on the day following the date the Disability benefits end under the Short Term Disability Income Benefit; that is, following the first two Benefit Years.

### **Class 1 Insureds**

The Disability benefit will be 10% of the Regular Monthly Contract Salary up to a Maximum Salary to be covered of \$300,000.00. This Disability Benefit, together with all Deductible Sources of Income shall not exceed 80% of Your Regular Monthly Contract Salary.

### **Class 2 Insureds**

The Disability benefit will be 66 2/3% of the Regular Monthly Contract Salary up to a Maximum Salary to be covered of \$300,000.00, less any Deductible Sources of Income.

## DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include:

- (a) income which You are eligible to receive from Your employer;
- (b) disability benefits You receive or which You are eligible to receive under any other group disability insurance plan, including those required under any employer's liability law; or
- (c) disability, pension or retirement benefits, including the Public Employees Retirement System any governmental plan, including Social Security benefits or negotiated alternative Social Security benefit plans payable to You and Your dependents which You are eligible to receive, regardless of whether application has been made for such benefits, except that:
  - (1) military disability allowances and/or military service retirement benefits received due to prior service connected disabilities, are excluded, unless You apply for these after You become Disabled;
  - (2) disability allowances and service retirement benefits received under the California State Teachers Retirement System, or the Public Employees Retirement System are excluded during the first 6 Months of Disability.

In the case of other group disability insurance which provides for a reduction of benefits payable under this group disability income policy, Our liability under this group disability income policy shall equal its pro rata share of the Disability Benefit. The pro rata share shall be determined by dividing the Disability Benefit by the benefit payable under all group disability income policies under which You are entitled to receive benefits and multiplying that result by the Disability benefit.

If We determine that You may qualify for benefits under item (c) listed above, We may estimate the amount of benefits You may be entitled to receive.

Your Disability benefit will not be reduced by the estimated amount if You:

- (a) apply for benefits under item (c) listed above and submit proof of application to Us; and,
- (b) appeal any denial received to all administrative levels We feel are necessary; and,
- (c) sign the Reimbursement Agreement form, which states You promise to repay any overpayment caused by receipt of benefits from a Deductible Source of Income for a period previously paid by Us at the time the benefits are received.

If Your Disability benefit has been reduced by an estimated amount, We will adjust the Disability benefit when proof is received:

- (a) of the amount awarded; or
- (b) that benefits have been denied and all appeals We feel necessary have been completed.

**REIMBURSEMENT OF OVERPAYMENT:** If You receive a lump sum payment from a Deductible Source of Income for a period previously paid by Us, any resulting overpayment made by Us will be due to Us on a lump sum basis.

**LUMP SUM RETIREMENT WITHDRAWALS:** If You have the option of taking retirement benefits on a monthly basis but choose to receive retirement benefits on a lump sum basis, We will assume You are receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

**INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS:** The Disability Benefit will not be reduced due to a cost of living increase if the increase from a Deductible Source of Income takes effect after the onset of Disability and while benefits are payable under the Policy.

**MINIMUM DISABILITY BENEFIT:** The Disability Benefit payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule of Benefits.

**IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING (applies to Long Term Disability Income Benefits Only)**

We will provide a Disability benefit if You are Disabled and Your monthly Disability Earnings, if any, are less than 20% of Your Regular Monthly Contract Salary due to the same Sickness or Accidental Injury.

If You are Disabled and Your Disability Earnings are greater than 20% of Your Regular Monthly Contract Salary due to the same Sickness or Accidental Injury, We will figure Your benefit as follows:

You will receive benefits based on the percentage of Regular Monthly Contract Salary You are losing due to Your Disability computed as follows:

- (a) subtract Your Disability Earnings from Your Regular Monthly Contract Salary;
- (b) divide the answer in item (a) by Your Regular Monthly Contract Salary. This is Your percentage of lost earnings; and
- (c) multiply Your Disability benefit by the answer in item (b).

We will stop payments and Your claim will end, if at any time You are no longer Disabled or if Your Disability Earnings exceed 80% of Your Regular Monthly Contract Salary or at the end of the Maximum Disability Period, whichever comes first.

**DISABILITY EARNINGS** means the gross monthly earnings You receive while Disabled and working.

The Elimination Period cannot be satisfied with days You are Disabled and working.

**TERMINATION OF BENEFITS**

Disability benefits will end on the earliest of these dates:

- (a) the date You are no longer Disabled;
- (b) the date Your Disability Earnings are more than 80% of Your Regular Monthly Contract Salary (applies to Long Term Disability Income Benefits Only);
- (c) the date You die;
- (d) the last day Disability benefits are made according to the Schedule of Benefits;
- (e) the date You fail to provide Us with written proof of Your Disability, satisfactory to Us;
- (f) the date You cease to be under the Regular and Appropriate Care of a Physician, refuse to undergo an examination by a Physician, or refuse vocational testing when We require such examination or testing;
- (g) the date You refuse to receive medical treatment that is generally acknowledged by Physicians to cure or improve Your condition so as to reduce its disabling effect;
- (h) the date You refuse to try or attempt to work with the assistance of:
  - (1) Modifications made to Your work environment, functional job elements or work schedule; or
  - (2) Adaptive equipment or devices,

that a Physician has indicated will allow a return to Your own occupation and which accommodations are approved by Your Employer.

**MENTAL ILLNESS LIMITED BENEFIT:** If You are Disabled due to a Mental Illness, regardless of the cause, Disability benefits will be provided for up to 6 months provided:

- (a) You are under the Regular and Appropriate Care of a Physician; and
- (b) You receive medical treatment (mental or medical examination alone will not be considered treatment) from either:
  - (1) a registered specialist in psychiatry;
  - (2) a Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary; or
  - (3) a Physician, if in our opinion, a specialist in psychiatry is not required to certify that such treatment is medically necessary.

After 6 months benefits will be paid only if You are confined to a Hospital.

**MENTAL ILLNESS** means Disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as:

- (a) schizophrenia;
- (b) depression;
- (c) manic depressive or bipolar illness;
- (d) anxiety;
- (e) personality disorders; and/or
- (f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

- (a) stroke;
- (b) trauma;
- (c) viral infection;
- (d) Alzheimer's disease; or
- (e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

**SPECIAL CONDITIONS LIMITED BENEFIT** If You are Disabled due to a Special Condition and You are under the Regular and Appropriate Care of a Physician, Disability benefits will be provided for the Special Conditions Period shown in the Schedule.

Special Conditions means:

- (a) Chronic Fatigue Syndrome.
- (b) Fibromyalgia.
- (c) Environmental allergic illness, including, but not limited to sick building syndrome and multiple chemical sensitivity.
- (d) Self-Reported Symptoms: Self-Reported Symptoms means the manifestations of Your condition that You tell Your Physician that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of Self-Reported Symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
- (e) Any disease, disorder, accident or injury of the neck or back not resulting in hemiplegia, paraplegia, or quadriplegia.

**ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT:** If You are Disabled due to alcoholism or drug addiction, a limited benefit of up to 14 days for each Disability will be paid. In no event will benefits be paid beyond the Maximum Disability Period shown in the Schedule. If drug addiction is sustained at the hands of, or

while under the Regular and Appropriate Care of a Physician in the course of treatment for Accidental Injury or Sickness, it will be covered the same as any other illness.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:** If You suffer loss of life, sight or limbs due to an Accidental Injury, an Accidental Death and Dismemberment Benefit as stated in the schedule, will be paid in accordance with the Time of Payments of Claims in the General Provisions Section for such loss if the following conditions are met:

- (a) the loss must result directly from an Accidental Injury;
- (b) the loss must occur within 90 days after the date of the Accidental Injury; and
- (c) the loss must not be excluded under the Exclusions Section.

If You die and the Accidental Death and Dismemberment Benefit applies, such benefit will be increased 1% for each full month that Your Certificate was continuously in force just prior to death. The increase shall not be more than 60%.

The benefit amount payable for a loss which meets the conditions stated above is as follows:

For Loss of Life	100% of the Accidental Death and Dismemberment Benefit
For Loss of One Hand	50% of the Accidental Death and Dismemberment Benefit
For Loss of One Foot	50% of the Accidental Death and Dismemberment Benefit
For Loss of One Eye	50% of the Accidental Death and Dismemberment Benefit
For Loss of more than one of the above in any one Accidental Injury	100% of the Accidental Death and Dismemberment Benefit
For Loss of Thumb and Index Finger on One Hand	25% of the Accidental Death and Dismemberment Benefit

“Loss” means, with regard to a hand or foot, actual severance through or above the wrist or ankle joints; with regard to an eye, entire or irrecoverable loss of sight; with regard to thumb and index finger on one hand, severance through or above the metacarpalphalangeal joints. Only one of the amounts, the greatest, will be paid for more than one loss resulting from the same Accidental Injury.

**SURVIVOR BENEFIT:** When We receive proof that You have died, We will pay Your Eligible Survivor a lump sum benefit equal to the amount shown on the Schedule, if on the date of Your death:

- (a) Your Disability has continued for 90 or more consecutive days; and
- (b) You were receiving or were entitled to receive Short Term Disability Income Benefits under the Policy.

If You have no Eligible Survivor(s), no payment will be made.

**ELIGIBLE SURVIVOR** means Your spouse, if living, otherwise Your dependent children. Dependent children must be under age 25 and unmarried the day You die. The term dependent children include a stepchild, adopted child and foster child. A stepchild or foster child must be dependent on You for support and maintenance.

**WAIVER OF PREMIUM:** If You become Disabled due to a covered Accidental Injury or Sickness, and are eligible to receive a Disability Payment, Your insurance will be continued without payment of premium. Waiver of Premium will begin the first of the month following:

- (a) Your satisfaction of the Elimination Period; or
- (b) 3 months of continuous Disability,

whichever is later, provided premium has been paid from the beginning of Disability to the date Waiver of Premium begins.

Waiver of Premium will continue until:

- (a) the end of Your Disability;
- (b) the end of the Maximum Benefit Period;
- (c) the date You are no longer eligible to receive a Disability benefit;
- (d) the date the Policy terminates; or
- (e) the date Your employment with the Policyholder or subscribing unit ends,

whichever first occurs. We will require proof on an annual basis that You remain Disabled during said period.

## **PRE-EXISTING CONDITION LIMITATION**

If Disability is due to a Pre-Existing Condition and begins before You have been continuously covered under the Policy for 24 months, no Disability benefit will be payable. This provision will not apply if you have:

- (a) gone treatment-free;
- (b) incurred no expense;
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for 12 consecutive months for such condition(s).

Benefits will not be excluded for Disability due to a Pre-Existing Condition, which begins after You have been continuously covered under the Policy for 24 months.

Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by Us.

## SECTION 4 EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, which results from:

- (a) A disability which starts while You are not working on a regularly scheduled basis due to lay-off, labor disputes or any Leave of Absence;
- (b) intentionally self-inflicted injury while sane or insane;
- (c) **War:** War or acts of war when serving as a member of any military, airforce, naval organization, or an auxiliary unit thereto. This exclusion includes Accidental Injury sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war or act of war. We will refund the pro rata unearned premium for any such period You or Your dependent are not covered.
- (d) Accidental Injury sustained or Sickness contracted while in the service of the armed forces of any country;
- (e) committing a felony;
- (f) penal incarceration. We will not pay benefits for Disability or any other loss for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer; or
- (g) Accidental Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which you are entitled to Workers' Compensation\*.

\*The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which You are entitled to Workers' Compensation benefits.

## **SECTION 5** **TERMINATION OF INSURANCE**

Your insurance coverage will end on the earliest of these dates:

- (a) the date You do not meet the Eligibility requirements as defined in Section 2;
- (b) the date You retire;
- (c) the date You cease to be on Active Employment as defined in Section 1, except as provided for under the Leave of Absence provision in this Section;
- (d) the end of the last period for which premium has been paid;
- (e) the date the Policy is discontinued; or
- (f) the first day of the month after the date on which You enter full-time military, naval or air service.

If:

- (a) Your coverage ends as a result of Your termination of Active Employment;
- (b) such termination is caused by an Accidental Injury or Sickness for which Disability Benefits would be payable; and
- (c) Disability is established prior to the termination of Active Employment,

then Disability Benefits will be paid as if such termination had not occurred.

Termination of the Policy will have no affect on Disability benefits which began before such termination.

We may end the coverage if You make a fraudulent claim.

We or the Policyholder may end the Policy on any premium due date. Thirty-one (31) days advance written notice of such termination must be given.

We may end the coverage of a Subscribing Unit if fewer persons are insured than the Policyholder's application requires.

**LEAVE OF ABSENCE:** Your coverage may be continued for up to 1 year during a Leave of Absence approved in writing by Your Employer. If You become Disabled while on an approved Leave of Absence, and Your Disability continues beyond the date of Your scheduled return to Active Employment, benefits will become payable after satisfaction of the normal benefit Elimination Period which will commence with the date of Your scheduled return to Active Employment, provided You re-enroll and premium payments are resumed for Your coverage.

**RE-ENROLLMENT AFTER LAYOFF OR LEAVE OF ABSENCE OR LABOR DISPUTE:** If Your insurance terminates because You ceased Active Employment because of a temporary layoff, leave of absence not due to Disability, or a labor dispute, You may re-enroll for coverage without furnishing evidence of good health provided You submit a new enrollment application within 60 Days of Your return to Active Employment.

## **SECTION 6** **PREMIUM CALCULATION AND PAYMENT**

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of Your individual coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) Our Home Office; or
- (b) an authorized agent of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases Our liability, premium rates may be changed on the date the liability is increased.

**PREMIUM REFUND:** In the event of death of any person covered under the Policy, a Premium Refund may be due. Such refund will be made if death occurs prior to the end of the period for which premium has been paid. The Premium Refund will be figured on a daily pro rata basis and will be provided within 90 days from the date valid Proof of Death is received.

**PROOF OF DEATH** means an original, notarized death certificate.

## SECTION 7 GENERAL PROVISIONS

**ENTIRE CONTRACT-CHANGES:** The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) Your application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by You or the Policyholder are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of the Company. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Disability (as defined in the Policy) that starts after such 2-year period.

**GRACE PERIOD:** A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

**NOTICE OF CLAIM:** Written Notice of Claim must be given to Us at 9000 Cameron Parkway, Oklahoma City, Oklahoma, 73114, or to Our agent. Such Notice of Claim should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give Notice of Claim within that time, the claim may not be denied or reduced due to the delay. Notice of Claim, provided at Your expense, must show:

- (a) that You are under the Regular and Appropriate Care of a Physician;
- (b) the date Your Disability began;
- (c) the cause of Your Disability;
- (d) the appropriate documentation of Your Regular Monthly Contract Salary;
- (e) the extent of Your Disability, including restrictions and limitations preventing You from performing Your Regular Occupation; and
- (f) the name and address of any Hospital or institution where You received treatment, including all attending Physicians.

**PROOF OF LOSS:** Written Proof of Loss must be furnished to Us at 9000 Cameron Parkway, Oklahoma City, Oklahoma, 73114 in case of claim for loss for which the policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which We are liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

**CLAIM FORMS:** Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Proof of Loss. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Notice of Claim Provision; and
- (c) within the time stated in the Proof of Loss Provision.

**TIME OF PAYMENT OF CLAIMS:** All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written proof. Benefits for any other covered loss will be paid as soon as We receive written proof of such Proof of Loss. If the claim is not paid or denied within forty-five (45) days of receipt of proper Proof of Loss, interest on overdue claims shall bear simple interest rate of ten percent (10%) per year.

**PAYMENT OF BENEFITS:** All benefits will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate. If a benefit is to be paid to Your estate, or to You and You are not competent to give a valid release, We may pay up to \$1,000 of such benefit to one of Your relatives who is deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

**PHYSICAL EXAMINATION:** While a claim is pending, We have the right to have You:

- (a) examined as often as is reasonably necessary. We will pay for such examination; and/or
- (b) interviewed by an authorized Company representative to determine the extent of any Sickness or Accidental Injury for which you have made a claim. This right may be used as often as reasonably required.

**LEGAL ACTION:** No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

**CERTIFICATES:** An individual Certificate will be issued for delivery to You. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to You, only the last one issued will be in effect.

**MISSTATEMENT OF FACTS:** If relevant facts regarding You are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

**CONFORMITY WITH STATE LAWS:** A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

**CLAIM OVERPAYMENT:** We have the right to recover any overpayment(s) due to:

- (a) fraud;
- (b) any error We make while processing Your claim; and
- (c) Your receipt of Deductible Sources of Income.

With respect to (b) and (c), We cannot request a refund of an overpayment made to You more than 12 months after such payment is made unless You have agreed in writing to reimburse such overpayment. Your reimbursement to Us must be made in full. However, We will work with You to develop a reasonable method of repayment if You are financially unable to repay such overpayment. We will not recover more money than the amount overpaid to You.



9000 Cameron Parkway

AMERICAN FIDELITY ASSURANCE COMPANY

Oklahoma City, OK 73114

### PAID FAMILY LEAVE LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

**You or Your** as used throughout shall mean the Insured or the Insured's. **We, Us, Our** shall mean the Company.

### RIDER SCHEDULE

<b>Paid Family Leave Benefit Amount:</b>	60% of Your Regular Monthly Contract Salary not to exceed: 1. the Disability Benefit of the Base Policy 2. the amount for which premium is being paid.
<b>Elimination Period:</b>	waived
<b>Maximum Benefit Period:</b>	10 weeks in any 12-month period

### DEFINITIONS

**ACTIVE DUTY** means, for the purposes of administering paid Leave, full-time duty in the active military service of the United States and full-time National Guard duty, and deployment to a foreign country.

**BONDING** means Paid Family Leave used to bond with Your:

- (a) infant Child if You are the biological Parent, Spouse, or domestic partner, as defined by state or federal law. If You gave birth, Your bonding period will begin after You are considered medically recovered from the birth;
- (b) adopted Child; or
- (c) foster Child,

during the first 12 months of birth, adoption, or placement.

**CHILD** means a biological, adopted, or foster child, a stepchild, a legal ward, a child of a domestic partner (as defined by state or federal law), or a person to whom You stand In Loco Parentis.

**CONTINUOUS LEAVE** means Leave taken in a single block of time for a Qualifying Reason. This type of Leave extends for at least 3 consecutive days up to a maximum of 12 weeks in any 12-month period.

**ELIMINATION PERIOD** means the number of days listed in the Rider Schedule for which Your Paid Family Leave extends before You are eligible to begin receiving a monthly benefit. No benefits are payable during this period.

**FAMILY CARE GIVING** means Paid Family Leave used to provide care for Your Family Member with a Serious Health Condition.

**FAMILY MEMBER** means:

- (a) Your Spouse, domestic partner (as defined by state or federal law), Child, Parent or Parent-in-Law;
- (b) a person who stood In Loco Parentis to You when You were a minor Child; or
- (c) Your Grandchild, Grandparent, or Sibling.

**GRANDCHILD** means a Child of Your Child.

**GRANDPARENT** means a Parent of Your Parent.

**IN LOCO PARENTIS** means when one acts in place of a Parent, intentionally takes over parental duties, and is responsible for exercising day-to-day care and control fulfilling the Child's physical and psychological needs.

**INTERMITTENT LEAVE** means Leave taken in separate blocks of time (non-continuous) for a single Qualifying Reason. Intermittent Leave must be taken in intervals of no less than one full day of work under Your regularly scheduled employment.

**PAID FAMILY LEAVE (LEAVE)** means Your leave of absence due to a Qualifying Reason for which the required Proof of Loss is sent to Us.

**PARENT** means a biological, foster, or adoptive parent, a stepparent, a legal guardian, or other person who stood In Loco Parentis to You when You were a Child.

**PARENT-IN-LAW** means the Parent of a Spouse or domestic partner (as defined by state or federal law).

**QUALIFYING EXIGENCY** means a need arising out of Your Family Member's Active Duty service or notice of an impending call or order to Active Duty in the Armed Forces, including, but not limited to, providing for the care or other needs of the military member's Child or other Family Member, making financial or legal arrangements for the military member, attending counseling, attending military events or ceremonies, spending time with the military member during a rest and recuperation leave or following return from deployment or making arrangements following the death of the military member.

**QUALIFYING REASON** means any of the following reasons for which You are eligible for Paid Family Leave:

- (a) Bonding;
- (b) Family Care Giving; or
- (c) Qualifying Exigency.

**SERIOUS HEALTH CONDITION** means an illness, injury, impairment, or physical or mental condition of a Family Member that involves:

- (a) inpatient care in a hospital, hospice or residential medical facility; or
- (b) continuing treatment or supervision by a Physician.

We must receive Proof of Loss for the Serious Health Condition from the Family Member's Physician.

**SIBLING** means a person related to You by blood, adoption, or affinity through a common legal or biological Parent.

**SPOUSE** means the person to whom You are lawfully married.

## **BENEFITS**

We will pay You the Paid Family Leave Benefit Amount shown on the Rider Schedule for Leave taken up to the Maximum Benefit Period. Your Leave must extend for at least 7 days and be due to a Qualifying Reason.

You may take Continuous Leave or Intermittent Leave (non-continuous). However, benefits will only be payable in full-day increments based on Your regularly scheduled employment upon satisfaction of the Elimination Period.

If any benefit is to be paid for less than a full month, the amount payable will be reduced pro rata on the basis that one day's benefits equals one-thirtieth (1/30<sup>th</sup>) of the monthly Paid Family Leave Benefit Amount.

## **PROOF OF LOSS**

When applying for Paid Family Leave Benefits, We will require You to submit the following information:

- (a) dates of Your Leave; and
- (b) type of Leave, whether Intermittent or Continuous.

Additionally, the following Proof of Loss is required:

### **Leave for Family Care Giving:**

For Leave to care for a Family Member with a Serious Health Condition, certification from a Physician is required that includes:

- (a) a statement confirming the relationship between You and the Family Member;
- (b) the name and address of the Family Member;
- (c) a statement that the Family Member has a Serious Health Condition;
- (d) the date on which the Family Member's Serious Health Condition commenced;
- (e) the probable duration of the Family Member's Serious Health Condition;
- (f) a statement that You are needed to care for the Family Member;
- (g) an estimate regarding the frequency and anticipated duration of time that You are needed to care for the Family Member;
- (h) information from You that proves to our satisfaction the identity of the Family Member; and
- (i) a diagnosis and International Classification of Diseases Code.

### **Leave for Bonding:**

For Leave for Bonding, one of the following is required:

- (a) the Child's birth certificate;
- (b) a statement from the Child's health care provider stating the Child's birth date;
- (c) a statement from the health care provider of the person who gave birth stating the Child's birth date;
- (d) Declaration of Paternity;
- (e) foster care placement record;
- (f) official letter from the foster care agency;
- (g) Adoptive Placement Agreement;
- (h) Independent Adoption Placement Agreement; or
- (i) other evidence of relationship.

**Leave for a Qualifying Exigency:**

For Leave for a “Qualifying Exigency”, the following is required:

- (a) a copy of the Family Member’s Active Duty orders; or
- (b) a letter of impending activation from the Family Member’s commanding officer; or
- (c) other documentation in circumstances where You are unable to produce the Active Duty orders or letter of impending activation; and
- (d) a statement of the family relationship between the covered service member and You; and
- (e) the Family Member’s name and address; and
- (f) the dates or period of time for which Leave is requested; and
- (g) the underlying reason for the Qualifying Exigency.

**EXCLUSIONS**

In addition to the Exclusions listed in the Policy to which this Rider is attached, no benefits will be payable for:

- (a) any period for which Leave is being taken for Your own Serious Health Condition;
- (b) Leave for circumstances surrounding Your own military Active Duty status, or notification of an impending call or order to military Active Duty status, in support of a contingency military operation;
- (c) any period for which Your Employer has not approved Your Leave for Bonding, Family Care Giving, or Qualifying Exigency;
- (d) any period for which You are eligible for or receiving Disability benefits under the base Policy to which this Rider is attached; or
- (e) more than one Qualifying Reason for any one period of Leave.

**TERMINATION OF BENEFITS**

Benefits under this Rider will end on the earliest of:

- (a) the date Your Leave ends;
- (b) the date any requested Proof of Loss is not submitted;
- (c) the date You become eligible for Disability benefits under the base Policy to which this Rider is attached;
- (d) the end of the Maximum Benefit Period under this Rider; or
- (e) the date Your employment terminates.

## TERMINATION OF RIDER

Your coverage under this Rider will end on the earliest of:

- (a) the date the Certificate to which this Rider is attached terminates;
- (b) the end of the last period for which premium payment has been made to Us;
- (c) the date You notify Us in writing to terminate coverage;
- (d) the date this Rider is discontinued; or
- (e) the date the Policy is discontinued.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.



Christopher T. Kennedy  
Secretary

**NOTICE OF PROTECTION PROVIDED BY  
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

**COVERAGE**

▪ **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

▪ **Amounts of Coverage**

**The basic coverage protections provided by the Association are as follows.**

▪ **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**
  - 80% of death benefits but not to exceed \$300,000
  - 80% of cash surrender or withdrawal values but not to exceed \$100,000
- **Annuities and Structured Settlement Annuities**
  - 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

▪ **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website [www.califega.org](http://www.califega.org).

## **COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE**

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

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## NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at [www.califega.org](http://www.califega.org), or contact either of the following:

California Life and Health Insurance  
Guarantee Association  
P.O. Box 16860  
Beverly Hills, CA 90209-3319  
(323) 782-0182

California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street  
Los Angeles, CA 90013  
(800) 927-4357

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

**(THIS FORM IS NOT A PART OF YOUR CONTRACT)**

## **NOTICE OF THE RIGHT TO APPEAL**

You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request to American Fidelity Assurance Company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Your request for review must be filed within 90 days after receipt of the written notice of denial of a claim. A decision will be rendered by American Fidelity Assurance Company, within 90 days after receipt of your request for review. If special circumstances exist or additional information is needed, the decision shall be rendered as soon as possible, but no later than 90 days after receipt of the additional information necessary to evaluate your appeal. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent plan provisions on which the decision was based.

**FACTS****WHAT DOES AMERICAN FIDELITY CORPORATION (AFC)  
DO WITH YOUR PERSONAL INFORMATION?**

<b>Why?</b>	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
<b>What?</b>	The types of information we collect and share depend on the product or service you have with us. This information can include: <ul style="list-style-type: none"> <li>• Social Security number and income</li> <li>• account transactions and medical information</li> <li>• insurance claim history and employment information</li> </ul>
<b>How?</b>	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons AFC chooses to share; and whether you can limit the sharing.

Reasons we can share your personal information	Does AFC share?	Can you limit this sharing?
<b>For our everyday business purposes –</b> Such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report it to credit bureaus	Yes	No
<b>For our marketing purposes –</b> To offer our own products and services to you	Yes	No
<b>For our affiliates to market to you</b>	No	We don't share your information for this purpose
<b>For our affiliates' everyday business purposes –</b> Information about your transactions and experiences	Yes	No
<b>For our affiliates' everyday business purposes –</b> Other information about your insurability	Yes	No
<b>For our affiliates' everyday business purposes –</b> Other information about your creditworthiness	No	We don't share your information for this purpose
<b>For joint marketing with other financial companies</b>	No	We don't share your information for this purpose
<b>For non-affiliated third parties to market to you</b>	No	We don't share your information for this purpose

<b>Questions?</b>	Call 1-866-554-4722 or go to <a href="http://americanfidelity.com">americanfidelity.com</a> .
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<b>Who we are</b>	
<b>Who is providing this notice?</b>	American Fidelity Corporation (AFC)
<b>What we do</b>	
<b>How does AFC collect my personal information?</b>	<p>We collect your personal information, for example, when you:</p> <ul style="list-style-type: none"> <li>• Provide information to us in the application process.</li> <li>• Transact business with us, our affiliates, or others, such as additional products or services purchased, etc.</li> <li>• Have information provided by your employer, group plan sponsor, or association for any group product you may have.</li> <li>• Have information provided by consumer reporting agencies, such as credit relationships and history.</li> <li>• Have information provided from other sources outside AFC such as medical information, motor vehicle reports, etc.</li> <li>• Visit AFC's non-public Online Service Center Web Site.</li> </ul>
<b>Why can't I limit all sharing?</b>	<p>Federal law gives you the right to limit only:</p> <ul style="list-style-type: none"> <li>• Sharing for affiliates' everyday business purposes – information about your creditworthiness</li> <li>• Sharing for non-affiliated third parties to market to you</li> </ul> <p>State laws and individual companies may give you additional rights to limit sharing.</p>

<b>Definitions</b>	
<b>Affiliates</b>	<p>Companies related by common ownership or control. They can be financial and non-financial companies. AFC's affiliates include:</p> <ul style="list-style-type: none"> <li>• American Public Life Insurance Company</li> <li>• American Fidelity Administrative Services, LLC</li> <li>• Health Services Administration, LLC</li> <li>• American Fidelity Assurance Company</li> <li>• American Fidelity General Agency, Inc.</li> <li>• American Fidelity Property Company</li> <li>• American Fidelity Securities, Inc.</li> <li>• Balliet's, LLC</li> </ul>
<b>Non-affiliated third parties</b>	<p>Companies not related by common ownership or control. They can be financial and non-financial companies.</p> <ul style="list-style-type: none"> <li>• AFC does not share with non-affiliates so they can market to you.</li> </ul>
<b>Joint marketing</b>	<p>A formal agreement between non-affiliated third parties that together market financial products or services to you.</p> <ul style="list-style-type: none"> <li>• AFC does not jointly market financial products or services.</li> </ul>

<b>Other important information</b>	
<p>AFC maintains appropriate physical, electronic, and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. Physical and electronic files are kept in secure areas. We educate our employees about the importance of confidentiality and customer privacy. We also enforce employee privacy responsibilities. We apply the same privacy policies to former customers that we apply to current customers.</p>	



