The following section applies only to those persons
who are eligible for and have enrolled in the
Group Term Life and AD&D Plan

Group Term Life and AD&D Insurance Certificate

CITY OF AUBURN
24B597

If you have any questions regarding your group insurance plan, please send your correspondence to:

AIG Benefit Solutions
PO Box 30066
Tampa, FL 33630-3066

Policy issued by:

American General Life Insurance Company
Houston, Texas

The United States Life Insurance Company in the City of New York
New York, New York

National Union Fire Insurance Company of Pittsburgh, Pa.
New York, New York

AIG Benefit Solutions® is the marketing name for the domestic benefits division of American International Group, Inc.

The underwriting risks, financial and contractual obligations, and support functions associated with products issued by American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, Pa. are the issuing insurer's responsibility. The United States Life Insurance Company in the City of New York and National Union Fire Insurance Company of Pittsburgh, Pa. are authorized to conduct insurance business in New York. Policies are not available in all states.

AIG Benefit Solutions
Underwritten by
American General Life Insurance Company
Houston, Texas
(Herein called the Company)

2727-A Allen Parkway
Houston, TX 77019

CERTIFICATE OF INSURANCE

American General Life Insurance Company (the *Company*) certifies that certain eligible persons are insured for the benefits described in this certificate. This insurance is subject to the eligibility and effective date requirements described in the **ELIGIBILITY** section of this certificate.

IMPORTANT NOTICE

This certificate is a summary of the group policy provisions that affect **your** insurance. It is merely evidence of the insurance provided by such policy for CITY OF AUBURN (the Policyholder).

The group policy is a contract between the *Company* and the Policyholder. It may be changed or ended without notice to or consent of any *insured* person.

This certificate replaces any certificate previously issued by the *Company* to you under the group policy.

The benefits described in this certificate are provided by group policy no. 24B597.

The *Company* is providing this electronic version of the certificate at the request of the Policyholder. The Policyholder maintains the group policy, which includes a copy of the certificate. The group policy is available for you to review and copy. If there is any conflict between the information in this electronic version of the certificate and the group policy, the group policy will control in all respects.

PLEASE READ THIS CERTIFICATE CAREFULLY

CERTIFICATE INDEX

SCHEDULE OF BENEFITS

Eligible Class(es):

Class 1 - All active full-time employees

FULL-TIME means active work on the Policyholder's regular work schedule for the class of employees to which you belong. The work schedule must be at least 30 hours a week.

Policy Effective Date: July 1, 2013

Policy Anniversary Date: July 1, 2014, and each subsequent July 1

Waiting Period:

Present Eligible Persons ..... None

Future Eligible Persons ..... The first day of the month following 1 month in an eligible class

LIFE INSURANCE

Life Insurance

Life Insurance Benefit Amount	$20,000
Life Insurance Maximum	$20,000
Guaranteed Issue Amount	$20,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) Benefit

AD&D Principal Sum	$20,000
AD&D Insurance Maximum	$20,000

Life Insurance Reduction Schedule

65% of the scheduled amount at age 65
50% of the scheduled amount at age 70

AD&D Insurance Reduction Schedule

65% of the scheduled amount at age 65
50% of the scheduled amount at age 70

Section I DEFINITIONS

ACCIDENT means an event or occurrence that is sudden, unforeseen and unintended.

ACTIVE WORK/ACTIVELY AT WORK means performing normal duties for the Policyholder at the usual place of employment, an alternative work site at the direction of the Policyholder, or at a location to which the Policyholder requires the Insured to travel. An Insured will be considered Actively At Work on each regularly scheduled non-work day if he or she was Actively At Work on the immediately preceding scheduled work day, provided the Insured is not Totally Disabled.

ACTIVITIES OF DAILY LIVING (ADL) means the following activities:

- Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;
- Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility - the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and
- Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

AUTOMOBILE means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

BASIC EARNINGS means the Insured's annual compensation from the Policyholder.

Basic earnings includes:

- the Insured's average monthly compensation from the Policyholder during the Policyholder's prior tax year if the Insured was a Partner, Professional Corporation (P.C.) Partner, Owner-employee, Sole Proprietor and/or S-Corporation Shareholder;
- the average annual compensation received by the Insured's professional corporation from the Policyholder during the Policyholder's prior tax year. The *Company* will calculate annual earnings by adding the following items as reported on the applicable Schedule K-1, Schedule C, Form W-2, or S-Corporation federal income tax return, or by the number of months that the Insured was a Partner, Professional Corporation (P.C.) Partner, Owner-employee, Sole Proprietor and/or S-Corporation Shareholder if less than 12 months. This includes the Insured's:
  - ordinary income from trade or business activities;
  - guaranteed payments if he or she was a Partner;
  - net profit from the business;
  - compensation (as an officer), salary or wages, if he or she was a S-Corporation Shareholder

- the Insured's average annual rate of compensation from the Policyholder including:
  - average annual salary
  - regular hourly wages (but not for more than 40 hours a week)
  - commissions averaged over the preceding 24 months or the period of the Insured's employment if less than 24 months
- shift differential pay
- contributions the Insured makes through a salary reduction agreement with the Policyholder to:
  - an Internal Revenue Code (IRC) 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement;
  - an executive nonqualified deferral compensation arrangement
- amounts contributed to the Insured's fringe benefits according to a salary reduction agreement under an IRC section 125 plan.

Basic earnings does not include:

- bonuses
- overtime pay
- extra compensation
- the Policyholder's contributions on the Insured's behalf to any deferred compensation plan or pension plan
- income the Insured earns as a private contractor on IRS form 1099
- stock options

CHANGE IN FAMILY STATUS means:

- an Insured's marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
- the death of or divorce from an Insured's spouse;
- the death of or emancipation of a child;
- Spouse's loss of employment which results in a loss of group insurance; or
- change in classification from part-time to full-time or from full-time to part-time.

COGNITIVE IMPAIRMENT means that the Insured has been certified by a Physician as having a deterioration or loss in intellectual capacity, resulting from Injury, Sickness, Alzheimer's disease or similar forms of irreversible dementia, and the Insured needs another person's active help or verbal guidance for his or her own protection and the protection of others.

DAY CARE CENTER means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction.

Section I DEFINITIONS

DEPENDENT CHILD(REN) means the Insured's unmarried children, including natural, step, foster or adopted children from the moment of placement in the home of the Insured, at least of age and under age , (- if attending an accredited Institution of Higher Learning on a full time basis) and primarily dependent on the Insured for support and maintenance.

Any unmarried Dependent Children of the Insured covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if they remain continuously covered under the Policy. The *Company* may request that the Insured submit satisfactory proof of the Dependent Child(ren)'s incapacity and dependency to the *Company* within 60 days before the Dependent Child(ren) reach the age limit specified above. If the Insured fails to furnish the requested proof before the Dependent Child(ren) reach the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the *Company* may request that the Insured submit satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency to the *Company* on an annual basis.

If the Insured fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child(ren) will terminate at the end of that 31-day period.

EVIDENCE OF INSURABILITY means a statement or proof of a person's medical history upon which acceptance for insurance will be determined by the *Company*.

FAMILY COVERAGE means coverage in force under the Policy on an Insured's Eligible Dependents: (1) whom the Insured has elected to cover under the Policy; and (2) for whom premium has been paid.

GUARANTEED ISSUE AMOUNT means the amount of insurance that will be issued to an Insured Person without Evidence of Insurability. The Guaranteed Issue Amount for an Insured Person's Life Insurance is shown in the Schedule. For amounts in excess of the Guaranteed Issue Amount, Evidence of Insurability satisfactory to the *Company* may be provided at the Insured's expense.

IMMEDIATE FAMILY MEMBER means a person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted, stepchild, or foster child), aunt, uncle, niece, nephew, or grandchild.

INJURY means bodily injury that is the direct result of an Accident occurring while the Policy is in force with respect to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a covered loss.

INSTITUTION OF HIGHER LEARNING means any accredited institution that provides education or training beyond the 12th grade level, including, but not limited to, any state university, private college, or trade school.

INSURED means a person who is a member of an Eligible Class for whom premium has been paid while covered under the Policy.

INSURED DEPENDENT means an Insured Dependent Child, for whom premium is paid while covered under the Policy.

INSURED DEPENDENT CHILD means the Insured's Dependent Child, for whom premium is paid while covered under the Policy.

INSURED PERSON means the Insured or an Insured Dependent.

Section I DEFINITIONS

LOSS OF A HAND OR FOOT means complete severance through or above the wrist or ankle joint.

LOSS OF SIGHT OF AN EYE means total and irrecoverable loss of the entire sight in that eye.

MILITARY means the armed land, sea or air force of a nation.

PARAMILITARY means an organized, armed force on a Military pattern.

PHYSICIAN means a licensed practitioner of the healing arts acting within the scope of his or her license, who is not: (a) the Insured Person; (b) an Immediate Family Member; (c) residing with the Insured Person; or (d) retained by the Policyholder.

PRIOR PLAN means the Group Life Insurance and Accidental Death and Dismemberment Insurance carried by the Policyholder on the day before the Policy Effective Date.

SCHEDULE means the Schedule of Benefits section of the Policy.

SICKNESS means illness or disease diagnosed by a Physician.

SUPPLEMENTAL RESTRAINT SYSTEM means an air bag which inflates for added protection to the head and chest areas.

TOTAL DISABILITY/TOTALLY DISABLED means that, as a result of Injury or Sickness, the Insured is unable to engage in any occupation for which he or she is reasonably qualified by education, training or experience.

WAR OR INSURRECTION means an armed conflict between the Military or Paramilitary forces of two (2) or more political entities.

Section II ELIGIBILITY

Eligible Classes

All active full-time employees of the Policyholder, but not those who are temporary, part-time or seasonal.

Eligibility. Before becoming eligible for coverage under the Policy, a Waiting Period must be satisfied by each member of an Eligible Class as shown in the Schedule.

Insured's Effective Date. An Insured's coverage under the Policy will become effective on the latest of the following dates:

If Non-Contributory

1. the Policy Effective Date; or

2. the first day of the month following the date the person becomes eligible for insurance;

If Contributory

1. the first day of the month following the date the person applies for insurance, if such date is within 31 days of his or her eligibility date;

2. the first day of the month following the date the *Company* approves the application for insurance and any required Evidence of Insurability, if application is made more than 31 days after his or her eligibility date;

3. the date for which the first premium for the person's coverage is paid; or

4. the Policy Effective Date.

Late Entrants

The following limitations will apply to a later enrollment: If the person does not enroll within 31 days after becoming eligible, he or she may only apply for coverage within 31 days of a Change in Family Status. The date that the person is insured will be the first day of the month following the date the *Company* approves application for insurance and any required Evidence of Insurability.

Change in Family Status

A Change in Family Status means:

1. An Insured's marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;

2. The death of or divorce from an Insured's spouse;

3. The death of or emancipation of a child;

4. Spouse's loss of employment which results in a loss of group insurance; or

5. Change in classification from part-time to full-time or from full-time to part-time.

The Insured will be allowed to enroll or increase one increment if a Change in Family Status applies.

Section II ELIGIBILITY

Evidence of Insurability Requirement

Evidence of insurability is required if the person:

- is a late applicant, which means that he or she requests insurance more than 31 days after the date he or she is eligible;
- voluntarily canceled his or her insurance and is reapplying;
- applies after any of his or her coverage ended because he or she did not pay a required contribution, or
- has not met a previous Evidence of Insurability requirement to become insured under any plan the Policyholder has with the *Company*.

Any Life Insurance which is in excess of the Guaranteed Issue Amount or is subject to Evidence of Insurability shall become effective on the date the *Company* approves evidence that the person is insurable, subject to any applicable waiting period.

Actively At Work Requirement

If the person is not Actively at Work on the date his or her insurance would otherwise become effective, insurance will not be effective until the date such person returns to and remains Actively at Work.

Effective Date of Changes. Any change in the amount of an Insured's insurance due to a change in Basic Earnings will take effect on the date of such change. Any change in the amount of an Insured's insurance due to his or her becoming a member of another Eligible Class will take effect on the date of such change.

If the Insured is not Actively at Work on the date that an increase in his or her coverage is to take effect, such increase will be effective on the date the Insured returns to Active Work.

No Loss / No Gain

If a person is absent from work due to a physical or mental condition on the date his or her insurance would otherwise have become effective, the effective date of the person's insurance will be deferred until the date he or she returns to Active Work.

If the person was insured under the Prior Plan on the day before the Policy Effective Date and would be eligible for coverage on the Policy Effective Date; except that he or she is not able to meet the requirements of Actively at Work; then the coverage amount shown in the Schedule of Insurance will not apply to such person.

Instead, the person will be considered to be insured and the *Company's* coverage amount will be the lesser of:

1. the amount of Life Insurance and Accidental Death and Dismemberment Insurance under the Prior Plan; or

2. the amount of Life Insurance and Accidental Death and Dismemberment Insurance shown in the Schedule of Insurance, reduced by any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan.

The person will remain insured under this provision until the first to occur of:

1. the date he or she returns to Active Work;

2. the date his or her insurance terminates for a reason stated under the termination provision;

3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or

4. the last day the person would have been covered under the Prior Plan, had the Prior Plan not terminated.

Section III DATE INSURANCE ENDS

Insured's Termination Date. An Insured's coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the grace period);

2. at the end of the month following the date the Insured ceases to be a member of an Eligible Class;

3. the date the Policy terminates; or

4. the date the Insured notifies the *Company* in writing to discontinue his or her coverage.

With respect to Accidental Death and Dismemberment Insurance, termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from an accident that occurred while the Insured's coverage was in force under the Policy.

Reinstatement of Insurance. If insurance ends because the Insured ceases to be eligible for coverage as defined in this Certificate, coverage may be reinstated and no additional waiting period will apply if, within six months after the date the insurance ends, the Insured becomes a member of an Eligible Class.

Exceptions to Termination of Insurance. If the Insured terminates Active Work and if premium payments for his or her coverage are made when due, he or she may be considered to be Actively at Work, subject to the conditions set forth below.

1. If the Insured terminates Active Work due to temporary lay off or leave of absence, coverage may be continued until the earliest of the following dates:

   a. the date the Policyholder ceases to pay the Insured's premiums, or otherwise terminates the insurance; or
   b. 31 days from the date the Insured ceases to be Actively at Work; or
   c. the date the Policy terminates.

2. If the Insured terminates Active Work due to Injury or Sickness, coverage under the Policy may be continued in accordance with the Extension of Life Insurance provision. However, if the insured is not eligible for continuance under the Extension of Life Insurance Provision and is no longer Actively at Work due to injury or Sickness, then the longest they can be covered is for 12 months unless age 65 or older.

Suspension of Coverage During Military Service

The *Company* will suspend the Insured's insurance on the date he or she goes on active duty in the Military service of any country or international authority. Such duty will not include temporary active duty by reservists for military training that lasts 90 days or less. The *Company* will refund that part of any premium paid for the period of such suspension.

A person can place his or her insurance back in force without Evidence of Insurability or earned income as of the date of his or her discharge. To do so, he or she must apply in writing and pay the premium, both within 90 days after active duty ends.

The *Company* will base the person's premium on his or her age and class of risk when such person's insurance was suspended. If the person was disabled on or before the date of discharge, he or she must have recovered for at least 6 months before the *Company* will cover a later disability from the same cause.

Section III DATE INSURANCE ENDS

Continuation of Coverage While on Leave under the Family and Medical Leave Act

If an Insured is eligible for and the Policyholder approves a leave of absence under the Federal Family and Medical Leave Act of 1993 (FMLA) or any similar state law, his or her insurance will continue for a period of up to 12 weeks following the date the leave begins provided the Policyholder pays the required premiums in accordance with the provisions of the group policy. The *Company* may require written confirmation of the FMLA approval from the Policyholder.

The Insured is eligible for leave under this act in order to provide care:

- after the birth of a child
- after the legal adoption of a child
- after the placement of a foster child in his or her home
- to a spouse, child or parent due to their serious illness, or
- for the Insured's own serious health condition.

If the Insured does not continue his or her insurance during the FMLA leave, upon his or her return to active employment:

- no new waiting period will be applied
- no new pre-existing conditions exclusions or limitations will be applied, and
- no Evidence of Insurability will be required to reinstate the insurance in effect before the leave began.

Section IV BENEFITS

LIFE INSURANCE

Death Benefit. Upon receipt of due proof of death, the *Company* will pay the Life Insurance Benefit Amount(s) in force on the Insured's life at the time of his or her death, in accordance with the terms of the Policy. In no event will the total amount of Life Insurance in force for an Insured exceed the Life Insurance Maximum shown in the Schedule.

Reduction Schedule. The Life Insurance Benefit Amount(s) payable with respect to an Insured Person will be reduced to the Percentage of Scheduled Benefit when the Insured Person attains the ages shown in the Schedule. The Accidental Death and Dismemberment Insurance benefits payable with respect to an Insured Person will be reduced to the Percentage of Scheduled Benefit if the Insured Person has attained the ages shown in the Schedule on the date of the accident causing the loss.

These reductions will also apply to any insurance that is extended in accordance with the Extension of Life Insurance provision in this Policy. Any decrease in the amount of insurance due to age will take place on the Insured Person's birthday.

"Age" as used above refers to the age of the Insured Person on his or her most recent birthday, regardless of the actual time of birth.

"Scheduled Benefit" as used above refers to the applicable benefit amount shown in the Schedule that would otherwise be payable in the absence of any benefit reduction.

Extension of Life Insurance

Waiver of Premium Benefit. If the Insured becomes Totally Disabled before reaching age 60, his or her Life Insurance under this Policy will continue for one year from the date the Insured becomes Totally Disabled, provided that the Insured remains Totally Disabled, and premiums are paid when due. The Life Insurance benefit will be the same amount for which the Insured would have been eligible if he or she were not Totally Disabled, subject to any applicable benefit reduction. Insurance may be continued beyond such one-year period, provided:

1. the Insured furnishes proof satisfactory to the *Company*, at least nine months from the date such Total Disability began, that the Insured has been Totally Disabled continuously from the date the Total Disability began; and

2. such proof is furnished to the *Company* no later than one year after the date the Total Disability begins.

Upon submission of the required proof, premiums paid on the Insured's behalf during the Total Disability will be refunded. The *Company* will waive the required premium payments until the Insured is no longer Totally Disabled, provided the Insured: (a) furnishes proof that the Total Disability has continued uninterrupted; and (b) submits to a physical exam when required, as provided below.

Benefits will end on the earliest of the following dates:

1. the date the Insured ceases to be Totally Disabled;

2. the date the Insured fails to submit to a physical exam as required;

3. the date the Insured's Life Insurance would otherwise terminate as indicated in the Policy;

4. the date proof of Total Disability is not provided when due; or

5. the date the Insured reaches age 65.

If the Insured ceases to be Totally Disabled, premiums must be paid when due if insurance coverage is to be continued.

Physical Exam. The *Company* will have the right to have a Physician of its choice examine the Insured to establish any disability. The *Company* will pay for the exam. The Insured may be examined as often as reasonably necessary during the period of disability, but not more than once a year after he or she has been disabled for two years.

Conversion After Extension. When any applicable extension of benefits described in this section ends, the Insured may convert his or her coverage to an individual insurance policy, provided the Insured is Entitled to Convert as described in the Conversion Privilege provision.

Conversion Privilege

The Insured may convert his or her Life Insurance under the Policy to an individual policy if such insurance, or any portion of it, ends, provided the Insured is Entitled to Convert and, within 31 days after such insurance ends the Insured:

1. applies in writing to the *Company* at P.O. Box 30066, Tampa, Florida 33630-3066; and

2. pays the first premium.

Evidence of Insurability. No Evidence of Insurability will be required if the Insured converts to an individual policy under this Conversion Privilege.

Entitled to Convert. The Insured is Entitled to Convert his or her Life Insurance only if:

1. the Insured ceases to be a member of an Eligible Class as described in the Eligible Class(es) section of the Schedule;

2. the Policy terminates, provided the Insured has been covered under the Policy for at least five consecutive years immediately preceding such termination;

3. the Policy is amended to terminate the Eligible Class to which the Insured belongs, provided he or she has been covered under the Policy for at least five consecutive years immediately preceding such termination.

In no event will the Insured be Entitled to Convert if his or her coverage under the Policy ceases due to non-payment of the required premium.

Amount of Converted Life Insurance. If the Insured's coverage terminates because he or she is no longer a member of an Eligible Class, the amount of Life Insurance that he or she will be eligible to convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Insured's Life Insurance ends because the Policy is amended to terminate the Eligible Class to which he or she belongs, or if the Policy terminates, the amount of Life Insurance under the converted life policy will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time insurance ends, less any amount for which the Insured becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000.

Section IV BENEFITS

Type of Policy. The individual policy will be the *Company's* current offering and will be on a form customarily issued by the *Company*. However, such policy may not be term insurance. No disability or other supplemental benefits will be covered under the policy. The individual policy will go into effect at the end of the period during which the Insured is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the policy can be contested, such time periods will be deemed to have begun at the time the Insured was first covered under the Policy.

The premium will be based on the *Company's* rates for the individual policy form, the benefit amount, age and the class of risk to which the Insured belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

Death During the Conversion Period. If the Insured dies within the 31-day conversion period, the *Company* will pay a death benefit equal to the maximum amount the Insured could have otherwise converted.

Notice of Conversion Right. Notice of the Insured's right to convert to an individual policy will be presented to the Insured or delivered to the Insured's last known address within 15 days from the date his or her coverage ends. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.

Accelerated Life Insurance Benefit

If elected by the Insured, and subject to approval by the *Company*, a portion of the Insured's Life Insurance benefit may be paid before his or her death. To qualify for this benefit, the Insured must have been diagnosed as being terminally ill while insured under this Policy or must meet the qualifying conditions stated below. The Insured must apply for Accelerated Life Insurance benefits in writing on a form acceptable to the *Company*.

Qualifying Conditions

To qualify for this benefit, the Insured must: 1) be unable to continuously perform one or more Activities of Daily Living (ADL), without stand by help; 2) have a Cognitive Impairment; or 3) have a terminal illness.

Any activity of daily living the Insured is not able to perform, without stand by help, prior to the effective date of coverage will not be considered for qualifying for this benefit. Any Cognitive Impairments due to, caused by, or contributed by a cognitive condition that began prior to the effective date of coverage will not be considered for qualifying for this benefit.

Proof of Terminal Illness. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the *Company* that the Insured's life expectancy is 6 months or less from the date of application for this benefit. Proof of terminal illness must include certification from a Physician. The *Company* reserves the right to obtain a second or third medical opinion at its own expense.

Proof of other Qualifying Conditions. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the *Company* that the person meets the qualifying conditions. Proof must be certified by a Physician and in the form that is satisfactory to the *Company*. The *Company* reserves the right to obtain a second or third medical opinion at its own expense.

Section IV BENEFITS

Benefit Amount

The maximum benefit the Insured may receive under this provision is the lesser of:

1. 75% of the Insured's Life Insurance benefit shown in the Schedule, less the amount of any benefit already paid under this provision; or

2. $250,000.

However if the Insured's Life Insurance is scheduled to reduce within 6 months of the date application for this benefit is received by the *Company*, the Accelerated Life Insurance Benefit will be limited to the amount that would be available for accelerated payment after such reduction takes place.

The minimum Accelerated Life Insurance benefit the Insured may receive will be $1,000. Such benefit will be paid in a lump sum to the Insured, unless an alternate payment arrangement is requested by the Insured in writing and is approved by the *Company*. However, the minimum payment under such installment payment arrangement will be $500 per payment.

The receipt of this Accelerated Life Insurance benefit may be taxable. The Insured should seek assistance from a personal tax advisor with respect to receipt of this benefit.. No representations as to any issue of taxation of this benefit are made by the Company.

Effect on Life Insurance Benefits at Insured's Death. The Insured's Life Insurance Benefit Amount(s) shown in the Schedule will be reduced by any amount paid under this provision.

Termination of Accelerated Life Insurance Benefits. This benefit will terminate on the date the Insured's insurance under the Policy terminates. However, this benefit will continue to be available while the Insured is covered under the Extension of Life Insurance provision of the Policy.

Limitations. The *Company* will not provide benefits under this provision if:

1. the Insured would be required by law to use the benefit to meet the claims of creditors, whether in bankruptcy or otherwise;

2. the Insured is required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement;

3. the Insured's Life Insurance under the Policy has terminated;

4. each irrevocable beneficiary, if any, has disapproved payment of this benefit; or

5. the Insured's Life Insurance benefits under the Policy have been assigned.

Payees. Benefits will be paid in one lump sum to the insured, if living. If not living the *Company* may pay such benefits to the Insured's estate.

The *Company* will not be liable for such payment after it is made.

Section IV BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS AND COVERAGES

Principal Sum. As applicable to each Insured, Principal Sum means the amount(s) of insurance in force under this Policy on the date of the accident, as described in the Schedule. In no event will the total amount of Accidental Death and Dismemberment Insurance in force for an Insured exceed the AD&D Insurance Maximum shown in the Schedule.

As applicable to an Insured Dependent, Principal Sum means the amount of insurance in force under the Policy as described in the Schedule.

Accidental Death Benefit

If Injury to the Insured Person results in death within 365 days of the date of the Accident that caused the Injury, the *Company* will pay 100% of the Principal Sum.

Accidental Dismemberment Benefit

If Injury to the Insured Person results, within 365 days of the date of the Accident that caused the Injury, in any one of the Losses specified below, the *Company* will pay the percentage of the Principal Sum shown below for that Loss:

For Loss of	Percentage of Principal Sum
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
One Hand or One Foot	50%
Sight of One Eye	50%

If more than one Loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

Day Care Benefit

If an Insured suffers accidental death such that an Accidental Death benefit is payable under the Policy on the date of the accident causing death, the *Company* will pay a benefit on behalf of any Dependent Child under age 13 who: (1) is enrolled in a Day Care Center on the date of the Insured's death; or (2) enrolls in a Day Care Center within 365 days after the Insured's death. The benefit is payable for each year of the Dependent Child's enrollment in a Day Care Center. The total amount of the benefit each year is equal to the least of:

1. the actual cost of care for that Dependent Child charged by that Day Care Center for that year;

2. 5% (in 1% increments to 10% and then 5% increments to the maximum) of the Insured's Principal Sum on the date of the accident causing death; or

3. $2,500 (in $1,000 increments to $10,000 and then $5,000 increments to the maximum).

Section IV BENEFITS

The applicable portion of the yearly benefit for each period of enrollment is payable upon receipt of due proof of enrollment, but not more frequently than monthly.

The benefit is not payable for any period of enrollment in a Day Care Center before the date of the accident that caused the Insured's death. The benefit is not payable for any period of enrollment after the earlier of: (1) the date the Dependent Child reaches 13 years of age; or (2) the date four (4) years after the later of the date of the Insured's death or the date the Dependent Child first enrolls in a Day Care Center.

Exposure and Disappearance

If by reason of an accident occurring while an Insured Person's coverage is in force under the Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Person has suffered accidental death within the meaning of the Policy.

Repatriation of Remains Benefit

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, the *Company* will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $5,000 (in $5,000 increments to $100,000 and then in $25,000 increments to the maximum).

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

AIG Benefits Travel Assist℠ must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The *Company* reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AIG Benefits Travel Assist℠ in advance.

Exclusion 2 in the Exclusions section of the Accidental Death and Dismemberment Benefit provision in this Certificate does not apply with respect to this benefit.

Seat Belt and Air Bag Benefit

Seat Belt Benefit. If the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the Accident causing death occurs while the Insured Person is operating, or riding as a passenger in, an Automobile and wearing a properly fastened, original, factory-installed seat belt or, if the person is a Dependent Child, a properly installed and fastened child restraint device as defined by state law, the *Company* will pay this additional benefit. The amount payable for this additional benefit is $10,000.

Air Bag Benefit. If a Seat Belt Benefit is payable and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the *Company* will pay an additional $10,000.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

Section IV BENEFITS

Tuition Benefit

If an Insured suffers accidental death such that an Accidental Death benefit is payable under the Policy on the date of the Accident causing death, the *Company* will pay the following benefit:

For the Dependent Children under Age 23. The *Company* will pay a benefit to or on behalf of any Dependent Child under age 23 who was insured under the Policy on the date of the Accident causing death and who, on the date of the Insured's death: (1) is a full-time student in any Institution of Higher Learning above grade 12; or (2) is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Insured's death. The benefit will be paid for each year of the Dependent Child's continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of four (4) consecutive years. The total amount of the benefit each year is equal to the least of:

1. the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Dependent Child;

2. 5% of the Insured's Principal Sum on the date of the Accident causing death; or

3. $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Insured's death. If there is no Dependent Child under age 23 eligible for the benefit within 365 days after the date of the Insured's death, the *Company* will pay a one-time lump sum benefit of 1000 to the Insured's designated beneficiary.

EXCLUSIONS

The Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at intentionally self-inflicted injury;

2. sickness, disease or infections of any kind, except bacterial infections;

3. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation on a regular schedule between established airports, if the Insured Person is:

   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or by the Insured Person's employer;

4. declared or undeclared War, or any act of declared or undeclared War;

5. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

6. the Insured Person being under the influence of drugs or under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a Physician; or

7. the Insured Person's commission of or attempt to commit a crime.

Section V CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the *Company* within 20 days after an Insured Person's loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the *Company* at 3600 Route 66, Neptune, New Jersey, 07753, with information sufficient to identify the Insured Person, is deemed notice to the *Company*.

Claim Forms. The *Company* will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 31 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured Person's name, Policyholder's name and the Policy number.

Proof of Loss. Written proof of loss must be furnished to the *Company* within 90 days after the date of loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the *Company* may reasonably require. Failure to furnish such proof within the time required, will not reduce or deny any benefits if the proof is given as soon as reasonably possible. However, in no event, other than legal incapacity, will proof be given more than one year after the date of loss.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured will be made to the Insured's beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured. If an Insured dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the *Company* may make an initial payment, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage of the payee who is deemed by the *Company* to be equitably entitled thereto. Such payment does not discharge the *Company's* liability for any remaining benefits payable under the Policy.

Any payment the *Company* makes in good faith fully discharges the *Company's* liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the *Company's* receipt of due written proof of the loss. Subject to the *Company's* receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the *Company* is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.

Section VI GENERAL PROVISIONS

Entire Contract; Changes. The Policy, the Master Application, and any attached papers make up the entire contract between Policyholder and the *Company*. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured will be used in any contest unless a copy of the statement is furnished to the Insured or his or her beneficiary or personal representative.

No change in the Policy will be valid until approved by an officer of the *Company*. The approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

Incontestability. The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium, misrepresentation or fraud.

After an Insured Person has been covered under the Policy for two years no statement made by the Insured Person will be used to contest a claim under the Policy. The *Company* can only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the Insured Person's beneficiary.

Interpretation of the Policy. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

If this policy comprises a part of an employee benefits plan, the *Company* is granted the sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of this policy. The *Company* has no responsibility or control with respect to any other benefit which may be provided beyond this policy or any other plan of benefits.

Beneficiary Designation and Change. The Insured's designated beneficiary(ies) is (are) the person(s) so named by the Insured for the Policy as shown on the Policyholder's records kept on the Policy. The Insured Dependent's beneficiary is the Insured.

A legally competent Insured over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the *Company*, Administrator, or broker or, if agreed upon in advance by the *Company*, the Policyholder with a written request for change. When the request is received by the *Company*, Administrator, or broker or, if agreed upon in advance by the *Company*, the Policyholder, whether the Insured Person is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the *Company* on account of any payment which is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Insured's (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured Person's estate.

If no beneficiary for an Insured Dependent's coverage is living on the date of the Insured Dependent's death, the beneficiary is the Insured's estate.

Section VI GENERAL PROVISIONS

Honoring Beneficiary Information from a Prior Plan. The Insured's beneficiary should be named on a form acceptable to the *Company*. If not, the *Company* may make all payments to the last person named by the Insured as a beneficiary under a policy that ended before becoming insured under the Policy.

The *Company* may use information from the prior carrier's records to determine any payment made such as:

1. information about the last beneficiary named by the Insured under the Policy, or any other group policy; or

2. information that the Insured named no beneficiary under the Policy, or any other group Policy.

If information shows that no beneficiary was named, the *Company* may make all payment to anyone it selects under the provisions for Payment of Benefits.

Physical Examination and Autopsy. The *Company* at its own expense shall have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy as often as it may reasonably require during the review of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements. Any express waiver by the *Company* of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the *Company* to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes. Any provision of the Policy which, as of its Policy Effective Date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

Workers' Compensation. The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

Clerical Error. A purely clerical error, which arises from other than a failure to perform administrative duties hereunder, whether by the Policyholder or the *Company*, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect; nor will it extend insurance of such person if that insurance would otherwise have ended or been reduced as provided in the Policy. Clerical error may be, by illustration but not limitation, errors in transcription or computation, but is not, by illustration but not limitation, a failure to advise Insured Persons of procedural requirements.

Assignment. The Policy is non-assignable. An Insured may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her beneficiary. The *Company* is not bound by an assignment until the *Company* receives and files a signed copy. The *Company* is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

Misstatement of Facts. If the material facts, including age, of the Insured Person were not accurate in the application to the Policy:

1. a fair adjustment of premium will be made; and

2. the true facts, including true age, will decide whether and in what amount of insurance is in force under the Policy.

Section VI GENERAL PROVISIONS

Facility of Payment. If an individual appears to the *Company* to be equitably entitled to compensation because he or she has incurred expenses on behalf of an Insured Person or for burial or funeral expenses, the *Company* may deduct from the amount payable under the Policy to be paid to such individual the expenses incurred, but not more than $2,000. Such payment will not exceed the amount due under the Policy.

Settlement Options. The Insured may elect to have all or any part of his or her Life Insurance Benefit Amount(s) paid to his or her beneficiary in installments or in any other way that may be agreed to by the *Company*. The Insured must give notice in writing to elect a settlement option. The Insured will have the right to change the election at any time. The terms of payment will be in accordance with those offered by the *Company* for the insurance at the time election is made.

After the Insured's death, the beneficiary:

1. may make such an election, if the Insured had not done so; and

2. may name a person(s) to receive any amount which would otherwise go to the beneficiary's estate; and

3. will have the right to change the person(s) named in accordance with 2. above.

Interest on Death Benefits Payable in a Lump Sum. Interest on Life Insurance Benefit Amount(s) paid in a lump sum for the loss of life of the Insured Person shall be paid to the Insured Person’s beneficiary. Such interest shall be computed daily at the rate of interest currently payable by the *Company* on proceeds left under the interest settlement option, from the date of death of the Insured Person to the date of payment. Such amount shall be added to and be a part of the total Life Insurance Benefit Amount(s) paid for loss of life.

Agency. For the purposes of the Policy, the Policyholder acts on its own behalf or as the agent of the Insured Person. Under no circumstances will the Policyholder be deemed the agent of the *Company* without written authorization.

NOTICE TO POLICYHOLDERS AND CERTIFICATE HOLDERS

Questions regarding your policy or coverage should be directed to:

American General Life Insurance Company
P.O. Box 30066
Tampa, Florida 33630-3066
877-672-1648

If you (a) need assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: 800-622-4461
In the Indianapolis Area: 317-232-2395

Complaints can be filed electronically at http://www.in.gov/idoi

INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
DISCLAIMER

The Indiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Indiana Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Indiana Life and Health Insurance Guaranty Association when selecting an insurer.

You may contact the Indiana Life and Health Insurance Guaranty Association as follows:

Indiana Life and Health Insurance Guaranty Association
251 East Ohio Street, Suite 1070
Indianapolis, IN 46204
(317) 636-8204
http://www.inlifega.org

You may contact the Indiana Department of Insurance as follows:

Indiana Department of Insurance
311 West Washington Street
Indianapolis, IN 46204
(317) 232-2385
http://www.in.gov/idoi

ADDENDUM TO SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by American General Life Insurance Company represents a portion of a Summary Plan Description required by the Employee Retirement Income Security Act of 1974 to be distributed to participants in the Plan.

PLAN NAME:

PLAN SPONSOR: **CITY OF AUBURN**

SPONSOR'S EMPLOYER IDENTIFICATION NUMBER (EIN):

PLAN NUMBER:

TYPE OF PLAN: **GROUP TERM LIFE AND AD&D**

PLAN ADMINISTRATOR:

AGENT FOR SERVICE OF LEGAL PROCESS:

SOURCES OF CONTRIBUTIONS:

PLAN'S YEAR ENDS ON:

American General Life Insurance Company is granted sole discretionary authority, as Claims Administrator/Insurer, to determine eligibility, make all factual determinations and to construe all terms of the policy/plan. The Plan Sponsor may terminate the policy/plan, or, subject to American General Life Insurance Company's approval, may modify, amend or change the provisions, terms and conditions of the plan. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured or any other person referred to in the policy/plan will be required to terminate, modify, amend or change the policy/plan. See your Plan Administrator to determine what, if any arrangements may be made to continue your coverage beyond the date you cease active work.

STATEMENT OF ERISA RIGHTS

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan Administrator with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate the Plan are called "fiduciaries." They have a duty to operate the Plan prudently and for your interest and for the interest of other Plan participants and the beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way so as to prevent you from obtaining a benefit or exercising your rights under ERISA.

ADDENDUM TO SUMMARY PLAN DESCRIPTION

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Claims Administrator/Insurer review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay court costs and fees. If you lose, and the court finds your claim was frivolous, it may order you to pay these costs and fees.

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

Claims Filing Procedures

To file a claim for a benefit, you should send written notice to the Claims Administrator/Insurer. The notice need only identify the claimant and the Policyholder or covered employer. When the Claims Administrator/Insurer receives the notice, they will send a proof of claim form to you. You should receive the proof of claim form within 15 days of the date the Claims Administrator/Insurer received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. Proof of claim must be sent within 180 days of the loss.

If a notice or proof is sent later than the times shown above, the Claims Administrator/Insurer will not deny or reduce a claim if the notice or proof was sent as soon as possible. The maximum time period to submit a proof of claim is one year from the date of the loss.

Claims for Benefits Under Life and Accidental Death and Dismemberment Plans

The Claims Administrator/Insurer will make an initial determination on life insurance claims within 90 days of receipt of due proof of loss. This period may be extended for up to an additional 90 days if special circumstances require an extension and the Claims Administrator/Insurer notifies you of the extension in writing before the end of the initial 90 day review period.

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You have 60 days to file an appeal of a denial of your claim. You may review pertinent documents and submit issues and comments in writing.

The Claims Administrator/Insurer will make a final decision no more than 60 days. This period may be extended for up to an additional 60 days if special circumstances (such as the need to hold a hearing) require an extension and the Claims Administrator/Insurer notifies you of the extension in writing before the end of the initial 60 day review period.