

GE GROUP LIFE ASSURANCE COMPANY certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

**POLICYHOLDER: TEMPLE UNIVERSITY**

EFFECTIVE DATE: JULY 1, 1994

ACCOUNT NUMBER: 354-6169-00

GROUP POLICY NO: 354-6169

STATE OF ISSUE: PENNSYLVANIA

This Certificate cancels and replaces any prior Long Term Disability Insurance Certificate issued to you.

This Group Certificate contains the terms of the Group Policy that affect your insurance. This Group Certificate is part of the Group Policy.

This Group Certificate is governed by the laws of the State of Issue shown above, which is the state of issue of the group policy.



President

GC-B-1.1

GROUP LONG TERM DISABILITY CERTIFICATE

LAST DATE PRINTED: June 14, 2002

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## PART 1: INSURANCE SCHEDULE

### LONG TERM DISABILITY INSURANCE

#### Coverage Eligibility:

ALL FULL-TIME FIRST AND SECOND YEAR MEDICAL STUDENTS

#### Eligible Class:

FIRST AND SECOND YEAR MEDICAL STUDENTS

#### Monthly Benefit:

The Monthly Benefit will be an amount equal to \$1,000, less any Other Income.

#### Elimination Period:

180 days per Period of Disability

#### Maximum Benefit Duration:

The greater of your normal Social Security retirement age as defined in the 1983 amendment to the Social Security Act or:

Age When Period of Disability Begins:	Duration
LESS THAN AGE 60	TO AGE 65
60	TO AGE 65
61	TO AGE 65
62	42 MONTHS
63	36 MONTHS
64	30 MONTHS
65	24 MONTHS
66	21 MONTHS
67	18 MONTHS
68	15 MONTHS
69 AND OVER	12 MONTHS

#### Pre-existing Limitation Periods:

TREATMENT FREE PERIOD: 30 DAYS

PRE-EXISTING LIMITATION PERIOD: 5 DAYS

WITH RESPECT TO DISABILITIES ARISING FROM A PRE-EXISTING CONDITION:

BENEFITS ARE EXCLUDED UNTIL YOU RETURN AS AN ACTIVE FULL-TIME MEDICAL STUDENT FOR 5 DAYS UNLESS ELIGIBLE FOR PRIOR SERVICE CREDIT.

## **PART 2: DEFINITIONS**

### **Active Full-time Medical Student**

A student who is attending the minimum number of courses required to maintain standing as a full-time Medical Student.

### **Any Occupation**

Any gainful occupation that:

1. You are or become qualified for by education, training or experience; and
2. Could result in earnings equal to at least the amount of your Monthly Benefit before offset by any Other Income.

### **Child**

The term "Child":

1. Means a child who is unmarried; receiving more than 50% of support from you; and either under 19 years of age or a Full-time College Student under 25 years of age; and
2. Is limited to your natural born child or other child related to you by blood; your stepchild; your foster child; or your legally adopted child.

### **Continuing Care**

You visit a Physician whose medical specialty is the most appropriate specialty to evaluate, manage or treat your Sickness or Injury and you receive care and treatment as frequently as is medically necessary.

### **Consumer Price Index**

The Consumer Price Index (C.P.I.-W) is published by the U.S. Department of Labor. It measures the change in the cost of a typical urban wage earner's or clerical worker's purchases of certain goods and services. The change in cost is expressed as a percentage of the cost of the same goods and services in some base period.

We reserve the right to use some other similar measurement if the U.S. Department of Labor changes or stops publishing the CPI-W.

### **Covered Student**

An Active Full-time Medical Student who is in a classification eligible for insurance as shown in the INSURANCE SCHEDULE.

### **Dependent**

The term "Dependent" includes:

1. Your lawful spouse; and
2. Your Child or Children.

### **Elimination Period**

The number of consecutive days of a Period Of Disability, shown in the INSURANCE SCHEDULE, which must be completed before we will pay you the Monthly Benefit. No benefits will be paid to you for any portion of your Period Of Disability that occurs during the Elimination Period.

During the Elimination Period, a Disability that is caused by the same or related Sickness or Injury will be considered as continuous even if you cease to be Disabled and again become an Active Full-time Medical Student for a period not to exceed the applicable number of trial recovery days. Ten trial recovery days are provided for every 30 days in the Elimination Period to a maximum of 60 trial recovery days.

We will not count these trial recovery days toward satisfaction of the Elimination Period. However, if you become eligible for insurance under another group long term disability policy, the terms of this provision will not apply.

## Full-time College Student

A Child who:

1. Is attending on a full-time basis a college or university licensed as such by the state in which it is located; and
2. Is enrolled for at least the minimum number of course credits required by such college or university to maintain standing as a full-time student.

## Injury

A bodily injury resulting directly from an accident and independently of all other causes.

## Mental Illness

Any mental, nervous or emotional disorder without demonstrable organic origin.

## Participation in a Riot

The words "Participation" and "Riot" in this phrase mean:

Participation - includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot - includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, acting with a common intent and where damage to person or property or unlawful act or acts is the intent or the consequences of such disorder.

## Period Of Disability

The number of consecutive days that you are Disabled beginning with the first day you are:

1. Disabled; and
2. Under the regular and Continuing Care of a Physician for the Sickness or Injury causing your Disability.

## Physician

A person who fulfills all requirements of 1., 2., and 3. below:

1. Is a legally qualified physician or health care practitioner.
2. Is acting within the scope of his or her license.
3. Is someone other than a member of your immediate family.

Immediate family is limited to:

- a) you;
- b) your spouse; and
- c) parents, brothers, sisters or children of either you or your spouse, whether related by blood or marriage.

## Pre-existing Condition

A Sickness or Injury for which you, during the Treatment Free Period (as shown in the INSURANCE SCHEDULE) before the effective date of your insurance under the policy:

1. Received medical care, treatment or advice; or
2. Took any drugs, medicine or medication prescribed or recommended by a Physician.

## Prior Policy

The Group Plan of Long Term Disability Insurance:

1. Provided through or sponsored by the Policyholder; and
2. Under which you were insured on the day before the effective date of this plan.

## **Prior Policy Benefit**

The benefit that would have been paid to you under the Prior Policy for your Disability had you remained insured under that policy.

## **Proof**

Any information that is:

1. Required by us under the terms of the policy; and
2. Satisfactory to us.

## **Regular School Year**

The period of time commencing on the first day of the fall semester and ending on the last day of the spring semester as defined by the Policyholder.

## **Retirement Plan**

A Retirement Plan is:

1. A defined benefit plan; or
2. A defined contribution plan.

The term Retirement Plan will not include the following:

- a) a profit-sharing plan;
- b) a thrift plan;
- c) a deferred compensation plan;
- d) a non-qualified pension plan;
- e) an Individual Retirement Account (IRA);
- f) a Tax Sheltered Annuity (TSA);
- g) a salary reduction plan (401K);
- h) a Keogh plan (HR-10) with respect to Partners;
- i) a retirement plan under a Professional Service Corporation with respect to Principals;
- j) an Employee Stock Ownership Plan (ESOP).

## **Sickness**

Disease or illness, Mental Illness, Substance Abuse or pregnancy.

## **Substance Abuse**

Alcoholism, the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance.

## **Total Disability and Totally Disabled (Disabled)**

Total Disability must be caused by Sickness or Injury and must commence while you are insured under the policy. You will be considered Totally Disabled if during and beyond the Elimination Period you are unable to:

- 1) Perform all the material and substantial functions of an Active Full-time Medical Student;
- 2) Fulfill the requirements necessary to maintain your status as an Active Full-time Medical Student.

## **You (Your)**

The Covered Student.

## **We (us, Our)**

GE Group Life Assurance Company

## **PART 3: COVERED STUDENT INSURANCE**

### **Date of Eligibility**

Only Employees who are Active Full-time Medical Students in an Eligible Class as shown in the INSURANCE SCHEDULE are eligible for coverage under this plan.

You will be eligible for insurance on the later of:

1. The effective date of insurance shown on the first page; or
2. The first day of the calendar month in which you first attend classes as an Active Full-time Medical Student.

### **Effective Date of Insurance**

Your insurance will become effective on the date you become eligible.

### **Increases in Insurance**

If for any reason there is an increase in the amount of insurance or benefits for which you are eligible, whether due to a change of classification or otherwise, you will be insured for such increased amount or benefits on the date of the increase.

You must, however, be an Active Full-time Medical Student on that date. Otherwise, you will be insured for such increased amount or benefits on the date you are again an Active Full-time Medical Student.

If you are not an Active Full-time Medical Student on such date solely because such date was not a regularly scheduled school day, you will be deemed an Active Full-time Medical Student on that date.

### **Decreases in Insurance**

If there is a decrease in the amount of insurance or benefits for which you are eligible, you will be insured for such decreased amount or benefits on the date of the decrease.

## **PART 4: MONTHLY BENEFIT**

### **Who Is Eligible For The Monthly Benefit**

We will pay you the Monthly Benefit shown in the INSURANCE SCHEDULE for a Period Of Disability, subject to all of the terms of the policy, if you satisfy the following conditions:

1. You must send Proof to us that you have become Disabled;
2. You must be insured under the policy at the time your Disability commences;
3. You must be under the regular and Continuing Care of a Physician for the Sickness or Injury causing your Disability; and
4. You must have completed the Elimination Period shown in the INSURANCE SCHEDULE.

### **Calculation Of The Monthly Benefit**

The Monthly Benefit we will pay each month while you are Disabled is equal to the Monthly Benefit shown in the INSURANCE SCHEDULE reduced by all Other Income benefits, as defined in PART 5: OTHER INCOME.

The Monthly Benefit will be payable subject to all the terms of the policy.

### **When The Monthly Benefit Is Paid**

The Monthly Benefit will be paid:

1. At the end of each consecutive monthly period, following the Elimination Period, during the uninterrupted continuance of your Disability; and
2. In an amount that is equal to 1/30 of the Monthly Benefit for each day of a Period Of Disability, following the Elimination Period, that is less than a full month.

### **When Payment Of The Monthly Benefit Ends**

We will continue to pay you the Monthly Benefit during a Period Of Disability, subject to all the terms of the policy, until the earliest of:

1. The date you cease to be Disabled.
2. The date you reach the Maximum Benefit Duration shown in the INSURANCE SCHEDULE.
3. The date you fail to give us required Proof that you are still Disabled.
4. The date you refuse to allow an examination we request.
5. The date you are no longer under the regular and Continuing Care of a Physician.
6. The date you die.
7. The date you become eligible for any other Group Long Term Disability coverage.

## PART 5: OTHER INCOME

### Other Income

Other Income means those benefits or amounts you receive as indicated below:

1. Any temporary or permanent award under:
  - a) any Workers' Compensation Law;
  - b) any Occupational Disease Law;
  - c) any other similar act or law.
2. Any disability benefits provided under:
  - a) any other group insurance plan; however, the amount of these benefits will be determined on a pro rata basis considering the liability of the other group insurance plan.
  - b) any Retirement Plan.
3. Any amount of disability or retirement benefits under:
  - a) the United States Social Security Act to which;
    - i) you are entitled; and
    - ii) your Dependents may be entitled because of your disability or retirement;
  - b) the Railroad Retirement Act;
  - c) any other similar act or law provided in any jurisdiction.
4. Any earnings you receive from any employment.

## **Application for Other Income**

If you, your spouse, child, or children are or become eligible for any Other Income, you, your spouse, child, or children must:

1. Apply for such Other Income; and
2. Cooperate with us in making reasonable efforts to reapply for or appeal the denial of any application for such Other Income.

Until approval or denial is made we will, at your option, make payments under either Method A or B below:

**Method A:** We will estimate the amount of Other Income you will receive and reduce your Monthly Benefit by this amount. If Other Income benefits are estimated, your Monthly Benefit will be adjusted when we receive Proof of the amount awarded or that benefits have been denied. If your application is denied, the amount estimated will be returned to you in a lump sum. During subsequent appeals Method B will be used.

**Method B:** Subject to your written agreement, we will pay your Monthly Benefit with no reduction for estimated Other Income until any Other Income payor reaches a decision. When a decision is reached, you must send us a copy of such decision and reimburse us in full for any overpayment we have made as a result of that decision, regardless of whether or not your coverage is still in force on the date you recover such amount. Additionally, if an award is made, we will reduce your Monthly Benefit by the amount of Other Income you receive, in accordance with the terms of the policy. If you choose this Method B and have not applied for other benefits to which you may be entitled, you must agree to apply for such benefits immediately. If you do not apply we will automatically use Method A.

You are not required to apply for any early Retirement Plan benefits.

## **Cost of Living Freeze**

If you receive a Cost of Living Increase, with regard to your Other Income, after the effective date of the benefits payable under this plan, we will not further reduce your Monthly Benefit by such cost of living increase. For purposes of this provision a Cost of Living increase is any annual increase reasonably related to the annual increase in any generally recognized cost of living measurement that applies to all persons who are entitled to receive such benefits.

## **Lump Sum Payments**

If any Other Income is paid in a lump sum, we will reduce the Monthly Benefits paid or payable by the monthly equivalent of that sum as determined below:

1. Over the period of time for which the sum is given, if a period of time is stated; or
2. If such period of time cannot be determined we will prorate the lump sum over a period of 60 months from the date of the lump sum award.

## PART 6: INDEMNITY FOR ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT

### Accidental Dismemberment and Loss of Sight Benefit

We will pay you the Monthly Benefit shown in the INSURANCE SCHEDULE for the lesser of the number of months shown in the Loss and Benefit Duration Schedule below, or the Maximum Benefit Duration regardless of the continuance of your Disability, if you satisfy the following conditions:

1. You sustain an Injury that results in one of the losses listed below within 100 days of a covered accident;
2. You send Proof to us of such loss;
3. You are insured under the policy at the time of such Injury; and
4. You have completed the Elimination Period shown in the INSURANCE SCHEDULE.

### Loss and Benefit Duration Schedule

Loss:	Number of Monthly Benefits:
For the loss of the sight of both eyes entirely, irrecoverably, and uncorrectably	48 months
For permanent loss of both hands by severance at or above the wrist joint	48 months
For permanent loss of both feet by severance at or above the ankle joint	48 months
For permanent loss of one hand by severance at or above the wrist joint and permanent loss of one foot by severance at or above the ankle joint	48 months
For permanent loss of one hand by severance at or above the wrist joint and the loss of the sight of one eye entirely, irrecoverably and uncorrectably	48 months
For permanent loss of one foot by severance at or above the ankle joint and loss of the sight of one eye entirely, irrecoverably and uncorrectably	48 months
For permanent loss of one hand by severance at or above the wrist joint or permanent loss of one foot by severance at or above the ankle joint	24 months
For the loss of the sight of one eye entirely, irrecoverably and uncorrectably	12 months

### Payments of Benefits

No combination of losses other than the ones shown above can be used to extend the Number of Monthly Benefits beyond the durations as shown above. If you sustain more than one of the above losses in any one accident, we will pay you for the one loss with the greatest number of monthly payments. Benefits may still be payable to you after the Number of Monthly Benefits have been paid if you are still Disabled and have not received the Maximum Benefit Duration specified in the INSURANCE SCHEDULE, subject to all of the terms of the policy.

### Claim Payments

If you die before all payments are made, we will pay benefits in accordance with the "Facility of Payment" section of LONG TERM DISABILITY CLAIM PROVISIONS in this certificate. Such benefits will be paid monthly.

## **PART 7: SURVIVOR BENEFIT**

### **When We Will Pay A Survivor Benefit**

If you die while receiving benefits under this plan, we will pay a benefit to your Eligible Survivor if:

1. Your current Period of Disability lasted for at least 180 consecutive days; and
2. You were receiving a Monthly Benefit from us for such current Period Of Disability at the time of your death.

### **Amount We Will Pay Your Eligible Survivor**

If the above conditions are met, we will pay your Eligible Survivor, the lesser of:

1. Three times your Monthly Benefit for the month prior to your death; or
2. The maximum amount allowable by state law.

Only one lump sum will be paid regardless of the number of Eligible Survivors. If there is more than one Eligible Survivor, said lump sum will be paid in equal shares to such persons.

### **Who Is An Eligible Survivor**

The term Eligible Survivor means your lawful spouse, if living at the time of your death; otherwise, your Child or children living at the time of your death. If there are no eligible survivors, this benefit will be paid in accordance with the "Facility of Payment" provision as described in the LONG TERM DISABILITY CLAIM PROVISIONS of this Certificate.

## **PART 8: EXCLUSIONS AND LIMITATIONS**

### **I. Exclusions**

Long Term Disability Benefits will not be paid:

1. For any Period Of Disability due to or resulting from:
  - a) war, declared or undeclared, or any act of war or any resistance to armed invasion or aggression, or international police action.
  - b) active Participation in a Riot.
  - c) attempted suicide or intentionally self-inflicted Injury.
  - d) participation in the commission of a felony.
2. While you are not under the regular and Continuing Care of a Physician for the Sickness or Injury causing your Disability.
3. For any Period of Disability due to or resulting from a Pre-existing Condition, unless otherwise stated in the INSURANCE SCHEDULE, if you received medical care or advice for such condition. This exclusion, however, will not apply:
  - a) if your Disability commences after the Pre-existing Limitation Period (as shown in the INSURANCE SCHEDULE) has expired while this insurance coverage is in force; or
  - b) if you are eligible for the Prior Service Credit as described below in the "Limitations" section.
4. During the Elimination Period.
5. For any Period Of Disability that occurred prior to your becoming insured under the policy.
6. For any Period Of Disability that does not commence during the Regular School Year.

### **II. Limitations**

#### **Mental Illness**

If a Period of Disability is caused by Mental Illness, the Monthly Benefit will be paid for not more than a total of 24 months during a Period Of Disability. Benefits, however, may be paid beyond the 24 month period under the following circumstances:

1. While you are confined in a hospital or institution that is licensed to give care and treatment for Mental Illness and is not a place primarily for convalescent care, provided:
  - a) you were confined prior to the end of the said 24 month period;
  - b) the confinement lasts for at least 14 consecutive days during which treatment is being rendered for such disability; and
2. During a period of recovery that follows a confinement described in item 1 above. Such benefit will be paid one time during a Period Of Disability provided that you continue to be Disabled for the lesser of:
  - a) 90 days; or
  - b) the period of recovery.

## **Prior Service Credit**

We will pay benefits under this plan for a Period Of Disability that is caused by a Pre-existing Condition subject to the following conditions:

1. You were insured under the Prior Policy on a premium paying basis on the day before the effective date of this plan;
2. You became insured under the policy on its effective date; and
3. You can satisfy the Pre-existing Condition requirements of the Prior Policy after we combine the period of time you were insured before the start of your Total Disability under:
  - a) the Prior Policy; and
  - b) this plan.

## **PART 9: WAIVER OF PREMIUMS**

### **Waiver of Premiums**

We will continue your Long Term Disability Insurance without payment of premiums while you are Disabled and receiving benefit payments from us.

### **Termination of Waiver of Premiums**

This continuance will end on the date your benefit payments end. In this case, you may again become insured for Long Term Disability Insurance if:

1. You are again an Active Full-time Medical Student;
2. Premium payments for the cost of your Long Term Disability Insurance are resumed; and
3. The Policyholder continues this Group Policy.

## **PART 10: SUCCESSIVE PERIODS OF DISABILITY**

### **When A Disability Will Be Considered A New Period of Disability**

If, after receiving a Monthly Benefit under this plan, you resume being an Active Full-time Medical Student or work at Any Occupation for 6 full months or more and again become Disabled by the same or related Sickness or Injury, your Disability will be considered a new Period Of Disability.

If, after receiving a Monthly Benefit under this plan, you resume being an Active Full-time Medical Student or work at Any Occupation and again become Disabled but your Disability is due to a Sickness or Injury that is unrelated to the cause of your prior Period Of Disability, your Disability will be considered a new Period Of Disability.

You must complete a new Elimination Period in either case.

### **When A Disability Will Not Be Considered A New Period of Disability**

If after receiving a Monthly Benefit under this plan, you resume being an Active Full-time Medical Student or work at Any Occupation for less than 6 full months and again become Disabled by the same or related Sickness or Injury, your Disability will be considered a continuation of the same Disability. You will not have to complete a new Elimination Period.

### **When This Part Will Not Apply To You**

If you become eligible for any other Group Long Term Disability Coverage, this Part will no longer apply to you.

## **PART 11: TERMINATION PROVISIONS**

### **Termination of Covered Student Insurance**

The LONG TERM DISABILITY INSURANCE coverage for you will automatically cease on the earliest date shown below:

1. On the date you are no longer an Active Full-time Medical Student in a class eligible for insurance;
2. On the date the policy terminates.
3. On the date you go on a leave of absence.
4. On the date the group policy is amended to terminate coverage for the classification of students to which you belong.

### **Termination Without Prejudice**

Any termination will be without prejudice to any claim arising prior to such termination, provided you are Disabled on the date of termination. If you are an Active Full-time Medical Student as of the date of termination and have previously received a Monthly Benefit under this plan, then subsequent coverage will be determined as described in the SUCCESSIVE PERIODS OF DISABILITY part of this Certificate.

## **PART 12: GENERAL PROVISIONS**

### **The Policy and Application**

The group policy issued to the Policyholder, together with the application of the Policyholder, is the entire contract between us and the Policyholder. All statements that the Policyholder or you, the Covered Student, make are deemed to be representations and not warranties. No written statement signed by you will be used in any legal action against you unless we give you or your representative a copy.

### **Changes To The Policy**

We and the Policyholder can change the policy in its entirety or with respect to any or all class or classes of Employees at any time if we and the Policyholder agree in writing to make such a change. Any such change will not be valid without the consent of any person other than the Policyholder and us. All such changes will be signed by our President, Vice President, Secretary or Treasurer and countersigned by one of our registrars or our President, Vice President, Secretary or Treasurer. No agent may change or waive any of the policy provisions; nor can an agent make any agreement that would be binding on us.

### **Limit Of Premium Refunds**

Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the 12 month period that preceded the date we learned of such overpayment.

### **Clerical Error**

Clerical errors in connection with the policy or delays in keeping records for the policy whether by us or the Policyholder:

1. Will not terminate insurance that would otherwise have been effective;
2. Will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

### **Misstatement Of Age**

If the relevant age of any Covered Student relating to this insurance is not accurate:

1. If appropriate, a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section.
2. The true facts will decide whether, and in what amount, and for what duration insurance is valid under the policy.

### **Time Periods**

All time periods referred to in the policy will begin and end at 12:01 A.M. standard time at the Policyholder's home office.

### **Waiver of Policy Provision**

If at some time we choose not to enforce a policy provision, we still retain our right to enforce that provision at any other time. To be effective, a waiver of any of the terms of the policy must be in writing and signed by a person authorized by us to waive such terms.

### **Assignment**

You cannot assign any interest in the policy.

### **Notice**

Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

## **PART 13: LONG TERM DISABILITY CLAIM PROVISIONS**

### **Notice of Claim**

You must send written notice of your claim:

1. Before the end of the Elimination Period;
2. To our Home Office; and
3. With enough information to identify you and the Policyholder.

If you cannot send notice within this time, we will not deny or reduce your claim if you can prove that notice was sent as soon as reasonably possible.

### **Claim Forms**

We will send claim forms to you within 15 days after we receive your notice of claim. If we do not send the forms, you can send us written Proof of your Disability within the time shown in "Proofs of Loss".

### **Proof of Loss**

To aid in the determination of benefits payable, you will be required to submit all Proofs of claim on forms satisfactory to us within 90 days after the Elimination Period. If you cannot send such Proof within this time limit, it must be sent as soon as reasonably possible; but in no event, except in the absence of legal capacity, later than one year after the time such Proof is otherwise required.

As part of Proof of Loss, we have the right to require:

1. Clinical evidence substantiating your Sickness or Injury;
2. Your signed statement identifying all Other Income benefits;
3. Proof that you and your dependents have applied for all Other Income benefits that are available; and
4. Business and financial records or any other pertinent financial documentation we may deem necessary.

We may require additional Proof of your claim at any reasonable time during the Period of Disability. Any additional Proof of your claim must be returned to us within 30 days after we request it.

### **Examination**

While a claim is pending or after payments have commenced, we have the right to have you examined by a Physician of our choice as often as is reasonably necessary. Approval of claim for benefits and the continuation of benefits are subject to your cooperation in submitting to such examination.

### **Legal Actions**

For 60 days after the written Proof of claim as required by us has been filed, no legal or equitable action may be brought against us for that claim. No action at all may be brought against us after 3 years from the date on which written Proof of claim is required.

### **Time Limits**

The time limits for giving notice of claim, Proof of claim or filing legal action will be changed to comply with the minimum requirements of any applicable law.

## Workers' Compensation

This insurance does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

## Facility of Payment

Benefits will be paid monthly. We will pay you all benefits (other than any benefit due solely to your death), if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator, or committee and we will pay to such person or persons; or
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
3. There are remaining benefits payable at the time of your death. In such case, claim may be made for the unpaid amount by your executor or administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, pay the whole or any part of such benefit:

- a) to your lawful spouse, up to a cumulative amount of \$1,000; or
- b) if you have no lawful spouse, up to a cumulative amount of \$750 to any one or more of the following relatives in the following order of priority:
  - i) your child or children; or
  - ii) your mother or father.

Payments under all benefit provisions will be subject to this "Facility of Payment" section, if applicable.

## Non-Discrimination

In the administration of the plan, the Policyholder is obligated to treat you and other Covered Students in like situations fairly.

## **PART 14: ARBITRATION**

### **How Arbitration Works**

Any claim or controversy arising out of or relating to a decision by us as to whether or not you are Disabled may be settled by arbitration in accordance with the Rules for Health and Accident Claims of the American Arbitration Association or by any other agreeable method. Judgement upon the award rendered by the Arbitrators may be entered in any court having jurisdiction over such awards.

### **Who Will Pay The Costs of Arbitration**

Any costs of said arbitration proceedings levied by the American Arbitration Association or the organization or person(s) conducting the proceedings will be paid by us.