ONEAMERICA®

AMERICAN UNITED LIFE INSURANCE COMPANY®
INDIANAPOLIS, INDIANA 46206-0368

Certifies that it has issued and delivered a policy to:

Tradesmen International, LLC

(Hereinafter called the Policyholder)

Policy Number: G 00616391-0000-000 Change Effective Date: Does Not Apply
Class: 001

This certificate replaces any and all certificates previously issued to the insured Person under the policy indicated above.

American United Life Insurance Company® (AUL) certifies that the Person whose enrollment form is on file with the Policyholder or AUL as being eligible for insurance and for whom the required premium has been paid is insured under the above numbered policy for group insurance benefits as designated in the Schedule of Benefits. Benefits as described in this certificate are subject to change.

This certificate describes the coverage provided in the policy. The policy determines all rights and benefits in this certificate and may be amended, cancelled, or discontinued at any time by agreement between AUL and the Policyholder without notice to the Person.

The policy may be examined at the main office of AUL during regular office hours.

Thomas M. Zurek
Secretary

J. Scott Davison
Chairman, President and Chief Executive Officer

CERTIFICATE OF INSURANCE
LUMP SUM DISABILITY INSURANCE

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SECTION 1 – SCHEDULE OF BENEFITS

ELIGIBLE CLASS	All Eligible Full-Time Corporate And Office Employees
CLASS NUMBER	001
REQUIREMENT FOR FULL TIME PARTICIPANTS	30.00 hours or more per week. See Section 3.
BENEFIT ELIGIBILITY PERIOD	24 months following the Elimination Period. See Section 2.
CHANGES IN INSURANCE	Anniversary. See Section 4.
CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)	This provision is included for this class. See Section 5B.
CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF	This provision is included for this class. See Section 5C.
CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE	This provision is included for this class. See Section 5D.
DEFINITION OF DISABILITY	Regular Occupation. See Section 2.
DEFINITION OF PERMANENT AND TOTAL DISABILITY	Any Occupation. See Section 2.
ELIMINATION PERIOD (EP) Accumulation of EP	90 days. See Section 2. 180 days. See Section 8.
GUARANTEED ISSUE AMOUNT (GIA)	$20,000
GUARANTEED INCREASE IN BENEFIT (GIB) GIB Amount	This benefit is included for this class. See Section 4. $1,000

SECTION 1 – SCHEDULE OF BENEFITS

CLASS NUMBER	001
INDIVIDUAL EFFECTIVE DATE	
Initial Participants	Policyholder's Effective Date if the Participant has satisfied his Waiting Period on or before said date, otherwise the first day of the Coverage Month following the Initial Enrollment Period. See Section 3.
New Participants	The first day of the Coverage Month following the Initial Enrollment Period. See Section 3.
INDIVIDUAL REINSTATEMENT	This provision is included for this class. Application must be made within 30 days from termination date. Effective first day of the Coverage Month. See Section 5A.
INITIAL ENROLLMENT PERIOD	
Initial Participants	Between 11/06/17 and 12/31/17.
New Participants	31 days following the Participant's Eligibility Date. See Section 3.
LIFE EVENT BENEFIT (LEB)	This benefit is included for this class. See Section 4.
Life Event Benefit Amount	$5,000
LIMITATIONS	
Drug and Alcohol Abuse Limitation	20% of the Lump Sum Disability Amount. See Section 10.
Mental Illness Limitation	20% of the Lump Sum Disability Amount. See Section 10.
Special Conditions Limitation	20% of the Lump Sum Disability Amount. See Section 10.
LUMP SUM DISABILITY BENEFIT AMOUNT	The Lump Sum Disability Amount is a flat amount available in $1,000 increments. The minimum Lump Sum Disability Amount is $10,000. The maximum Lump Sum Disability Amount is $50,000. See Section 8.
MAXIMUM LUMP SUM DISABILITY BENEFIT AMOUNT	$50,000
PARTICIPANT PREMIUM CONTRIBUTIONS	Contributory. See Section 3.
POLICY MONTH	A period that begins on the 1st day of January and ends on the 31st day of January. Each succeeding Policy Month runs for a similar period thereafter.
PORTABILITY PRIVILEGE	This privilege is included for this class. See Section 12.
PRE-EXISTING CONDITION EXCLUSION	
Duration	3/12. See Section 9.
RECURRENT RETURN TO WORK PERIOD	90 days. See Section 8.

SECTION 1 – SCHEDULE OF BENEFITS

CLASS NUMBER	001

REDUCTIONS: The Lump Sum Benefit Amount will begin reducing to percentages shown below on the Group Policyholder's first Anniversary Date following the date the Participant reaches age 65. The percentage of coverage remaining once the Participant attains various ages will be as follows:

STANDARD REDUCTION STARTING AT AGE 65 – ADEA COMPLIANT

PARTICIPANT'S AGE	REDUCED BENEFIT PERCENTAGE
65	70%
70	45%
75	30%
80	25%
85	20%
90	15%

SCHEDULED ENROLLMENT PERIODS	60 days prior to 12/31.
WAITING PERIOD	
Initial Participants	60 days
New Participants	60 days See Section 2.
WAIVER OF PREMIUM	This benefit is included for this class. See Section 6.

SECTION 2 – DEFINITIONS

ACTIVE WORK and ACTIVELY AT WORK means the regular and full-time use of time and energy in the services of the Person's Regular Occupation. The Person must be physically and mentally capable of performing each of the Material and Substantial Duties of his Regular Occupation on a regular full-time basis.

This includes time off for vacation, jury duty, paid holidays, and funeral leave, where the Person could have been Actively At Work on that day.

Active Work does not include periods of time when a Participant is not Actively At Work following an Injury, Sickness, strike, lock-out, layoff, after a Participant's employment has ended voluntarily or involuntarily, or periods of time the terminated Participant receives accrued vacation pay or other employment related benefits after his employment termination date.

BENEFIT ELIGIBILITY PERIOD means the period of consecutive days the Person is Disabled commencing the first day following the Elimination Period and continuing for the number of months identified in the Schedule of Benefits.

COSMETIC SURGERY means surgery that is performed to change the texture, shape, or structure of any part of the human body for the purpose of beautifying or creating a different visual appearance.

CONTRIBUTORY INSURANCE means insurance for which the Person pays part or all of the premium.

COVERAGE MONTH means that period of time beginning on the Person's Individual Effective Date, and continuing from the first day and ending on the last day of each succeeding Policy Month.

DATE OF HIRE means the first day the Participant is Actively At Work in an eligible class of the Policyholder.

DATE OF DISABILITY means the first date the Person is Disabled.

DISABILITY and DISABLED means that, due to Sickness or Injury, a Person during the Elimination Period and/or Benefit Eligibility Period:

1) is unable to perform one or more of the Material and Substantial Duties of his Regular Occupation on a full-time basis; or
2) is performing at least one of the Material and Substantial Duties of his Regular Occupation or another occupation on a part time basis and is working for the Policyholder less than 80% of his regular hours, that does not include overtime pay, during the six weeks prior to the Person's Date of Disability; and
3) is under the Regular Attendance of a Physician for that Sickness or Injury.

DUE DATE means the first day of the Coverage Month for which the premium is payable.

SECTION 2 - DEFINITIONS

ELIGIBILITY DATE means the date that a Participant, in an eligible class as stated in the Schedule of Benefits, has satisfied his Waiting Period and AUL determines is eligible for Personal Insurance under the policy.

ELIMINATION PERIOD means a period of consecutive days the Person is Disabled beginning on the Date of Disability.

EMPLOYER means the entity or organization for which the Person performs services and which has the right to control what will be done and how it will be done. An Employer has the right to control the details of how the services are performed by the Person. The Person must not be considered an independent contractor or agent unless classified by the IRS as a statutory employee of the Employer. The Employer is the entity or organization for which the Person performs his Regular Occupation, and is required to withhold and pay income, social security, and Medicare taxes on wages.

EMPLOYER'S RETIREMENT PLAN means any defined benefit or defined contribution plan that is sponsored by the Employer.

EVIDENCE OF INSURABILITY means a statement or proof of a Person's medical history, upon which acceptance for insurance will be determined by AUL.

FRANCHISE COVERAGE means disability insurance coverage which allows Participants to be insured as part of their relationship with the Policyholder but such coverage is not part of an employee welfare benefit plan and the Participants are insured under individual policies.

GUARANTEED INCREASE IN BENEFIT (GIB) means an additional amount of coverage that may be available to a Person once a year if certain specified conditions are met.

GUARANTEED ISSUE AMOUNT (GIA) means the amount of coverage that does not require Evidence of Insurability. This amount is stated in the Schedule of Benefits.

INDIVIDUAL REINSTATEMENT means that Personal Insurance that has been terminated due to cessation of Active Work may be reinstated in accordance with Section 5A of the policy.

INJURY means a sudden, unforeseen and unexpected event that occurs independently of all other causes and causes physical harm to the Person. This includes all other conditions related to the same Injury.

LIFE EVENT BENEFIT (LEB) means an increase or decrease in coverage resulting from specific events occurring in a Person’s life.

LUMP SUM DISABILITY BENEFIT means the benefit amount payable to a Person who is Permanently and Totally Disabled, according to the provisions of the policy as approved by AUL and stated in the Schedule of Benefits.

MALE PRONOUN whenever used includes the female.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:
1) are normally required for the performance of an occupation; and
2) cannot be reasonably omitted or modified.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the *Diagnostic and Statistical Manual of Mental Health Disorders (DSM)*, published by the American Psychiatric Association, most current as of the start of a Disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the *DSM* is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a Disability.

NON-CONTRIBUTORY INSURANCE means insurance for which the Person pays none of the premium.

PARTICIPANT means any individual who is a full-time employee, shareholder, owner, proprietor, partner, member, or corporate officer of the Policyholder:

1) whose employment with the Policyholder constitutes his principal occupation;
2) who works at that occupation a minimum number of hours as stated in the Schedule of Benefits;
3) who is working at the Policyholder's regular place of business which may include an alternative worksite if approved by the Policyholder and AUL;
4) who is not a part-time, temporary or seasonal Participant or worker;
5) who is authorized to work in the United States under applicable state and federal laws; and
6) if approved by AUL:
    a) who legally works and resides in Canada;
    b) who legally works in the United States and resides in Canada; or
    c) who legally works in Canada and resides in the United States.

PERMANENT and TOTAL DISABILITY and PERMANENTLY and TOTALLY DISABLED means that, due to Sickness or Injury, a Person is:

1) expected to be unable to perform the Material and Substantial Duties of any occupation for which he is reasonably fitted by training, education or experience on a full-time basis for a continuous period of not less than 24 months;
2) not working;
3) not engaged in any activity for profit, such as a business or investment activity;
4) not receiving income or revenue from an activity which is a hobby; and
5) under the Regular Attendance of a Physician for that Sickness or Injury.

If the Person's Regular Occupation requires a license, loss of this license for any reason does not in itself constitute Permanent and Total Disability.

PERSON means a Participant who has met the requirements of the ELIGIBILITY, ENROLLMENT AND INDIVIDUAL EFFECTIVE DATE section of the policy.

PERSONAL INSURANCE means the coverage provided under the policy for a Person.

PHYSICIAN means a qualified, state licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be recognized as a Physician, practicing within the scope of his license and applicable law. Physician does not include a Physician employed by the Policyholder, a Person or anyone related to a Person by blood, marriage, civil union, or domestic partnership.

SECTION 2 – DEFINITIONS

POLICYHOLDER means any sole proprietorship, partnership, member, corporation, limited liability company, limited liability partnership, firm, school district, individual school, union, association, organization, or instrumentality of a state or political subdivision thereof, that has been approved by AUL and to whom the policy is issued. An entity that is subsidiary to or affiliated with the Policyholder as defined below is eligible for coverage under the policy if it is shown on the Application or later added by amendment to the policy.

A subsidiary may be included in this definition when the Policyholder owns more than 50% of the voting stock of the entity.

An affiliate may be included in this definition when the entity is under common control with the Policyholder through 51% or more ownership and control.

The Policyholder is liable for all premiums due for subsidiaries and affiliates during any period of time a subsidiary and/or affiliate is insured under the policy. Any notice given to the Policyholder by AUL shall be considered notice given to the subsidiary and/or affiliate.

POLICYHOLDER'S EFFECTIVE DATE means the date on which coverage is actually effective for the Policyholder under the policy as determined by AUL.

POLICYHOLDER'S ANNIVERSARY DATE means 01/01 of each year.

PRE-EXISTING CONDITION means any condition for which a Person did or would have done any of the following at any time during the 3 months immediately prior to a Person's Individual Effective Date of Insurance, whether or not that condition was diagnosed at all or was misdiagnosed:
1) received medical treatment or consultation;
2) taken or were prescribed drugs or medicine; or
3) received care or services including diagnostic measures.

PRIOR PLAN means the Policyholder's plan of lump sum disability insurance or benefit plan having similar features to Lump Sum Disability that terminated on the day immediately before the Policyholder's Effective Date of coverage under the policy.

REGULAR ATTENDANCE means that a Person:
1) personally meets with or visits a Physician as medically required according to standard medical practice, to effectively manage and treat his Disability;
2) is receiving the most appropriate treatment and care that will maximize his medical improvement and aid in his return to work; and
3) is receiving care by a Physician whose specialty or clinical experience is appropriate for the Disability.

REGULAR OCCUPATION means a Person’s occupation as it is recognized in the general workplace and according to industry standards. The Person’s time, energy and services must be performed at the Policyholder's regular place of employment, or an alternative worksite approved by AUL. For Actively at Work requirements, a Person’s alternative worksite may not be located outside of the United States or Canada for more than 6 months in any 12-month period. A Person’s occupation does not mean the specific job tasks he does for the Policyholder or at a specific location. For example, an attorney’s Regular Occupation means the practice of law as defined under applicable laws versus a specialized area within the practice of law.

SICKNESS means illness, bodily disorder or disease, Mental Illness, normal pregnancy and complications of pregnancy. Complications of pregnancy are defined as concurrent disease or abnormal conditions significantly effecting the usual medical management of pregnancy.

SPOUSE means:
1) an individual to whom the Person is married; or

2) the Person's civil union partner or domestic partner, as defined by applicable law.

However, for purposes of insurance under the policy, Spouse does not include an individual from whom the Person is divorced or from whom the Person has dissolved a civil union or a domestic partnership.

SURVIVOR means a relative entitled to inherit under intestate succession laws, in the following order: a Person's Spouse, child(ren), grandchildren, great grandchildren, parent(s), siblings, nieces and nephews, grandparents, aunts and uncles.

WAITING PERIOD means the period of days, starting on the Date Of Hire, that a Participant must be continuously Actively at Work while in an eligible class. Initial Participants will be given credit for time served under the Policyholder's prior carrier if the policy replaced the same type of coverage he had with the prior carrier. The Waiting Period is stated in the Schedule of Benefits.

SECTION 3 – ELIGIBILITY, ENROLLMENT, AND INDIVIDUAL EFFECTIVE DATE

INITIAL PARTICIPANT means a Participant who is employed by the Policyholder before the Policyholder's Effective Date.

NEW PARTICIPANT means a Participant who is employed by the Policyholder on or after the Policyholder's Effective Date.

LATE ENROLLEE: A Late Enrollee is an Initial or New Participant who is Actively At Work, but does not request coverage during his Initial Enrollment Period.

ELIGIBILITY DATE: A Participant who is in an eligible class as stated in the Schedule of Benefits and has satisfied his Waiting Period, becomes eligible for Personal Insurance under the policy on:

1) *Initial Participant:*
   a) the Policyholder's original Effective Date of coverage under the policy; or
   b) the first day of the Coverage Month immediately following the Waiting Period.
2) *New Participant:* the first day of the Coverage Month immediately following the Waiting Period.
3) *Late Enrollee*: the first day of the Coverage Month following the next Scheduled Enrollment Period.

ENROLLMENT: To be considered for coverage, an eligible Participant must apply correctly and truthfully for Personal Insurance under the policy. Eligible Participants applying for Personal Insurance must complete and sign a written request for coverage on an enrollment form approved by AUL and pay the required premiums before coverage will become effective. This form will be given to and maintained by the Policyholder. Coverage may only be requested during an Initial or Scheduled Enrollment Period, as follows:

1) INITIAL ENROLLMENT PERIOD: The Initial Enrollment Period is the time during which an eligible Participant who is Actively At Work may first apply for coverage following completion of the Waiting Period without providing Evidence Of Insurability. An eligible Participant may waive coverage or request coverage under any option offered by the Policyholder for his class. The Initial Enrollment Period includes the following periods, during which a Participant may make his initial written application for coverage under the policy:
   a) *Initial Participant:* the Initial Enrollment Period, which is the period of time agreed to by AUL and the Policyholder and is stated in the Schedule of Benefits.
   b) *New Participant:* the Initial Enrollment Period, which is shown on the Schedule of Benefits as either:
      i) the period that begins on the Eligibility Date and continues through the number of days as shown on the Schedule of Benefits; or
      ii) the Scheduled Enrollment Period beginning on the Eligibility Date.

2) SCHEDULED ENROLLMENT PERIOD: This is a recurrent period of days, as stated in the Schedule of Benefits, after the Policyholder's original Effective Date, during which:
   a) a New Participant or eligible Late Enrollee may apply in writing, on an AUL approved enrollment form, for coverage under the policy; or
   b) an eligible Person may increase their Lump Sum Disability Benefit Amount by the Guaranteed Increase In Benefit Amount as stated in the Schedule of Benefits without Evidence of Insurability. See Section 4; or
   c) an eligible Person may increase their Lump Sum Disability Benefit Amount to an amount in excess of the Guaranteed Increase In Benefit Amount as stated in the Schedule of Benefits with satisfactory Evidence of Insurability. See Section 4.

   The Scheduled Enrollment Period is chosen by the Policyholder and must be approved by AUL.

3) DELAYED ENROLLMENT PERIOD: An eligible Initial or New Participant who is not Actively At Work during his Initial Enrollment Period may apply for Personal Insurance without providing Evidence of Insurability. He may do this if:
   a) he has returned to full-time Active Work;
   b) he is in an eligible class as stated in the Schedule of Benefits;
   c) his Waiting Period was completed prior to his cessation of Active Work; and
   d) he applies within 31 days of the day he returns to Active Work.

EVIDENCE OF INSURABILITY: Evidence of Insurability is required if:
1) the Participant applies for Lump Sum Disability Insurance in excess of the Guaranteed Issue Amount as stated in the Schedule of Benefits;
2) the Late Enrollee applies for Lump Sum Disability Insurance;
3) the Person applies for Lump Sum Disability Insurance in excess of the Guaranteed Increase In Benefit Amount as stated in the Schedule of Benefits; or
4) the Participant applies for Lump Sum Disability Insurance after termination of insurance due to failure to pay the required amount of premium timely.

Any amount of insurance for which the Participant or Person requests greater than the Guaranteed Issue Amount will only be available following written approval by AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If insurance for amounts greater than the Guaranteed Issue Amount is approved, coverage will begin on the date identified in writing by AUL. If an amount greater than the Guaranteed Issue Amount is not approved by AUL, the Lump Sum Disability Benefit Amount will be equal to the Guaranteed Issue Amount and will be effective as set forth in the Individual Effective Date of Insurance provision of the policy.

SECTION 3 - ELIGIBILITY, ENROLLMENT, AND INDIVIDUAL EFFECTIVE DATE

INDIVIDUAL EFFECTIVE DATE OF INSURANCE

Initial Participant:

1) The Individual Effective Date of Insurance for an eligible Initial Participant who has satisfied his Waiting Period prior to the Policyholder's Effective Date is the Policyholder's original Effective Date under the policy as long as an Initial Participant:
   a) requested coverage during the Initial Enrollment Period; and
   b) is Actively At Work for the Policyholder on that date.
2) The Individual Effective Date of Insurance for an eligible Initial Participant who has not satisfied his Waiting Period prior to the Policyholder's Effective Date is the first day of the Coverage Month following the Waiting Period for New Participants. The Individual Effective Date of Insurance for an eligible New Participant is the date of the request if that date is the first day of a Coverage Month; otherwise it is the first day of the next Coverage Month as long as the New Participant:
   a) requested coverage during the Initial Enrollment Period;
   b) has completed the Waiting Period for New Participants; and
   c) is Actively At Work on the Individual Effective Date of Insurance.

New Participant:
The Individual Effective Date of Insurance for an eligible New Participant depends on the Policyholder's selection on the Application, as described below.

First day of the Coverage Month following the Waiting Period for New Participants: The Individual Effective Date of Insurance for an eligible New Participant is the date of the request if that date is the first day of a Coverage Month; otherwise it is the first day of the next Coverage Month as long as the New Participant:

1) requested coverage during the Initial Enrollment Period;
2) has completed the Waiting Period for New Participants; and
3) is Actively At Work on the Individual Effective Date of Insurance.

EFFECTIVE DATE OF CHANGE (First of the Coverage Month & GIB)

A change in coverage that does not increase the amount of coverage becomes effective the earlier of:
1) the first day of the Coverage Month following any scheduled reduction;
2) the first day of the Coverage Month following AUL's written approval of the change, if the date is the first day of the Coverage Month; or
3) the first day of the next Coverage Month following AUL's written approval of the change, if the date is after the first day of the Coverage Month.

Prior to a change in coverage that increases the amount of coverage, the Person must be Actively at Work and the required amount of premium must be paid.

A change increasing the amount of coverage equal to or less than the GIB offer takes effect on:
1) the first day of the Coverage Month; if the Person becomes eligible for the change on the first day of the Coverage Month; or
2) the first day of the next Coverage Month following the date the Person becomes eligible for the change in coverage, if the date is after the first day of the Coverage Month.

A change in coverage increasing the amount of coverage above the Person's GIB offer is subject to:
1) satisfactory Evidence of Insurability, at no expense to AUL; and
2) AUL's written approval.

If the Person is not Actively at Work on the effective date of the approved increase, any increase in the amount of coverage takes effect on:
1) the first day of the Coverage Month if the Person returns to Active Work on the first day of the Coverage Month; or
2) the first day of the next Coverage Month following the Person's return to Active Work, if the date is after the first day of the Coverage Month.

SECTION 4 - CHANGES IN INSURANCE

DECREASING THE LUMP SUM DISABILITY BENEFIT AMOUNT: A Person may decrease the amount of his coverage at any time. Any decrease in coverage will become effective the first day of the Coverage Month following the date of the request.

Any change in insurance, other than a decrease in the amount of coverage or an increase in coverage to the next higher option as stated above, will require satisfactory Evidence of Insurability.

GUARANTEED INCREASE IN BENEFIT (GIB)

The Person may apply for the GIB, which is an additional amount of coverage, at each AUL approved Scheduled Enrollment Period without satisfactory Evidence of Insurability, if all the following conditions are met:

1) the Person must be under age 65;
2) the Person must be Actively at Work on the effective date of the increase;
3) the amount of each increase will be limited to the GIB Amount stated in the Schedule of Benefits;
4) the amount of coverage after the increase is not greater than the Maximum Lump Sum Disability Benefit Amount stated in the Schedule of Benefits;
5) the Person has not previously been declined for the GIB;
6) the Person applying for a GIB whose total amount of coverage exceeds the Maximum Lump Sum Disability Benefit Amount will be limited to the Maximum Lump Sum Disability Benefit Amount; and
7) the Person will be limited to six (6) GIB increases during the lifetime of the policy.

If reductions begin prior to age 65, the total amount of coverage following the GIB will be reduced according to the Reductions stated in the Schedule of Benefits.

If a Participant declines the Lump Sum Disability Insurance during the Initial Enrollment Period and wants to apply at a later Scheduled Enrollment date, receipt of any coverage will first require Evidence of Insurability and information satisfactory to AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage is approved, coverage will begin on the date identified in writing by AUL. If the Participant is approved for coverage during the Scheduled Enrollment, he will be eligible to apply for the GIB at the next Scheduled Enrollment Period.

If coverage is declined following unsatisfactory Evidence of Insurability, no GIB will be available until Evidence of Insurability and information is received. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If the GIB request is approved, coverage will begin on the date identified and approved in writing by AUL.

COVERAGE AMOUNTS REQUESTED IN EXCESS OF THE GUARANTEED INCREASE IN BENEFIT

During Scheduled Enrollment Periods, a Person may apply to increase an amount greater than the GIB, however, receipt of any amount above the GIB will first require Evidence of Insurability and information satisfactory to AUL. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage is approved, coverage will begin on the date identified and approved in writing by AUL.

If coverage for a Participant is declined following unsatisfactory Evidence of Insurability, no GIB will be available until Evidence of Insurability and information satisfactory to AUL is received. Until the GIB is approved, only the amount of coverage previously approved by AUL will be available.

LIFE EVENT BENEFIT (LEB)

A Person may request an additional amount of coverage without Evidence of Insurability, if all the following conditions are met:

1) The Person experienced one of the following Life Events:
   a) marriage;
   b) domestic partnership or civil union, as defined under applicable laws in the state of residence of the Person;
   c) birth of a child;
   d) adoption of a child or stepchild; or
   e) permanent legal custody or guardianship of a child lasting more than 90 days;
2) AUL was notified within 31 days of the Life Event;
3) the Person must be under age 65;
4) the Person must be Actively at Work on the effective date of the increase;
5) The amount of the LEB increase is offered in the Schedule of Benefits.
6) the amount of coverage after the increase is not greater than the Maximum Lump Sum Disability Benefit Amount stated in the Schedule of Benefits;
7) the Person has not previously been declined; and
8) the Person applying for a LEB amount that exceeds the Maximum Lump Sum Disability Benefit Amount, will be limited to the Maximum Lump Sum Disability Benefit Amount.

A Person may be eligible for a LEB for each Life Event when events are simultaneous. For simultaneous LEB events, the increased amount for each event will be based on the coverage amount prior to the LEB events and the amount of each increase will be equal. However, the amount of coverage after the increase will not be greater than the maximum amount of coverage available to the Person.

The LEB will be reduced according to the Reductions as stated in the Schedule of Benefits. In no event will the total amount of coverage including any LEB exceed the Maximum Lump Sum Disability Benefit stated in the Schedule of Benefits.

If a Participant declines coverage during the Initial Enrollment Period and wants to apply at a later Scheduled Enrollment date, receipt of any coverage first requires Evidence of Insurability and information satisfactory to AUL unless the Participant has a qualifying Life Event. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If coverage is approved, coverage will begin on the date identified in writing by AUL. If the Participant is approved for coverage during the Scheduled Enrollment, he will be eligible to request the LEB when a Life Event occurs.

If coverage for a Late Enrollee is declined following unsatisfactory Evidence of Insurability, no LEB will be available until Evidence of Insurability and information satisfactory to AUL is received. Approval will be based on Evidence of Insurability and information satisfactory to AUL. If the LEB request is approved, coverage will begin on the date identified in writing by AUL.

SECTION 5 - TERMINATIONS

INDIVIDUAL TERMINATION: A Person will cease to be insured on the EARLIEST of the following dates:

1) the date the policy or the Policyholder's coverage under the policy terminates;
2) the date the Person is no longer in an eligible class;
3) the date the Person's class, as stated in the Schedule of Benefits, is no longer insured under the policy;
4) the last day of the period for which premiums were paid, if the premium is not paid when due;
5) the date the Person requests termination, but not prior to the date of the request;
6) the date the Lump Sum Disability Benefit is paid to the Person;
7) the date the Person dies;
8) the date employment terminates. **Cessation of Active Work will be deemed termination of employment.** However, insurance will be continued for a Person:
   a) during the Elimination Period, if the Person is Disabled, as described in the policy;
   b) during the Benefit Eligibility Period, if the Person is Disabled, as described in the policy;
   c) during any period that premiums are being waived under the Waiver of Premium provision;
   d) during any temporary Leave of Absence according to the appropriate Continuation of Personal Insurance benefit, if premiums continue to be paid during the leave and the benefit was elected by the Policyholder in the Application and approved by AUL; and
   e) during any temporary layoff according to the appropriate Continuation of Personal Insurance benefit, if premiums continue to be paid during the layoff and the benefit was elected by the Policyholder in the Application and approved by AUL.

TERMINATION OF THE POLICY: Insurance coverage under the policy will cease on the EARLIEST of the following dates:

1) the date the Policyholder no longer meets the definition of a Policyholder;
2) the date the Policyholder ceases active business operations, becomes insolvent, or is placed in bankruptcy or receivership;
3) the date the Policyholder ceases to exist by means of transfer of ownership, transfer of control, sale, dissolution, merger, consolidation, acquisition, or otherwise;
4) the date ending the Policy Month for which the last premium payment is made for the Policyholder’s insurance;
5) at the end of a Policy Month, if the Policyholder has given AUL at least 31 days prior written notice;
6) the date the Policyholder fails to promptly furnish any information which AUL may reasonably require; or
7) the date the Policyholder, without good and sufficient cause, fails to perform in good faith its duties pertaining to the policy.

If a Person’s insurance is terminated due to the termination of the policy, the Person’s rights under the policy are terminated on the date the policy terminated.

Termination of the policy under any conditions will be without prejudice to AUL for any claim incurred prior to termination.

If the policy terminates, the Policyholder will be liable to AUL for all unpaid premiums for the period during which the coverage was in force.

SECTION 5A - INDIVIDUAL REINSTATEMENT

INDIVIDUAL REINSTATEMENT: If Personal Insurance terminates under the policy due to cessation of Active Work for the Policyholder, it may be reinstated subject to the terms of this provision. Individual Reinstatement must be requested during the 31-day period immediately following return to Active Work for the Policyholder in accordance with the terms stated in this provision. Individual Reinstatement will be for the same coverage amount and eligible class that the Participant belonged to immediately prior to his termination. AUL may require Evidence of Insurability if reinstatement is requested for an amount or eligible class that differs from the coverage the Participant had with the Policyholder immediately prior to his cessation of Active Work. Reinstatement is subject to payment of required premiums and that the Policyholder is currently insured by AUL under the policy. In addition to these requirements, the following also applies:

1) If a Participant returns to Active Work within the period of consecutive calendar days as stated in the Schedule of Benefits under Individual Reinstatement from his individual termination date and requests Individual Reinstatement:
   a) Personal Insurance will become effective immediately upon the date of request for Individual Reinstatement, or the first day of the Coverage Month immediately following the date of request for Individual Reinstatement, as stated in the Schedule of Benefits.
   b) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class held by the Participant under the policy immediately prior to cessation of Active Work.
   c) *If the Schedule of Benefits states that the Participant must return to Active Work within 30 days of termination:* Credit will be given towards satisfaction of the eligibility Waiting Period and of the Pre-Existing Condition exclusion or limitation period he previously served under the policy. However, any days accumulated during his period of lapse in coverage will not be credited. The original Individual Effective Date of Insurance will be used when applying the eligibility Waiting Period and the Pre-Existing Condition exclusion or limitation period.
   d) *If the Schedule of Benefits states that the Participant can return to Active Work for a period greater than 30 days from the Participant's date of termination:* Credit will be given towards satisfaction of the eligibility Waiting Period he previously served under the policy. However, any days accumulated during his period of lapse in coverage will not be credited. The Participant will be considered a New Participant and subject to the terms of the policy, except as stated herein.
2) If a Participant returns to Active Work more than the number of consecutive calendar days, shown in 1) above, after his individual termination date and requests Individual Reinstatement:
   a) The Participant will be considered a New Participant subject to the terms of the policy.
   b) Eligibility for Personal Insurance, Enrollment and his Individual Effective Date Of Insurance will be determined as stated in the policy.
   c) The Waiting Period and Pre-Existing Condition exclusion or limitation period will start anew. The Individual Reinstatement date will be used when applying the Pre-Existing Condition exclusion or limitation period.
3) If the Participant is currently insured under the policy's Portability Privilege and returns to Active Work with the Policyholder and requests Individual Reinstatement to the policy:
   a) Personal Insurance will become effective the first day of the Coverage Month immediately following the date of request for Individual Reinstatement, as stated in the Schedule of Benefits.
   b) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class held by the Participant under the policy immediately prior to cessation of Active Work.
   c) Credit will be given towards satisfaction of the Pre-Existing Condition exclusion or limitation period he already served under the policy and the Portability Privilege. The Participant's original Individual Effective Date of Insurance will be used when applying the Pre-Existing Condition exclusion or limitation period.
   d) Coverage under the Portability Privilege must terminate immediately prior to the date of Individual Reinstatement under the policy.

4) If Personal Insurance terminates because of a leave approved by the Policyholder under the Federal Family and Medical Leave Act (FMLA), or similar applicable state law, and the Participant returns to full-time Active Work immediately following the end of the leave:
   a) Personal Insurance will become effective immediately upon the date of request for Individual Reinstatement.
   b) Credit will be given towards satisfaction of the Pre-Existing Condition exclusion or limitation period previously served under the policy, however, the days accumulated during the period of lapse in coverage will not be credited. The original Individual Effective Date of Insurance will be used when applying the Pre-Existing Condition exclusion or limitation period.
   c) Evidence of Insurability will not be required for Individual Reinstatement to the same coverage amount and eligible class that the Participant would have been entitled to prior to the leave.

SECTION 5B - CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT

CONTINUATION OF PERSONAL INSURANCE UNDER THE FAMILY AND MEDICAL LEAVE ACT. If the Policyholder correctly approves a leave of absence under the Federal Family and Medical Leave Act (FMLA), a Person's coverage under the policy will be continued as stated in this Section. Personal Insurance will continue while a Person's leave is covered under FMLA, until the end of the later of:

1) the leave period permitted under FMLA; or
2) the leave period permitted by applicable state law.

Coverage continued under this Section is subject to the following requirements:

1) the Policyholder has approved a Person's leave in writing as a leave taken under FMLA;
2) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 – PREMIUM PAYMENT); and
3) the Lump Sum Disability Amount will be the amount in effect prior to the date the Person's family or medical leave began.

Continuation of Personal Insurance under this provision will cease on the EARLIEST of the following:

1) the date a Person dies;
2) the date a Person's coverage terminates for nonpayment of premiums;
3) the date a Person begins full or part-time employment with another employer;
4) the date the policy terminates;
5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
6) the date a Person's class is no longer offered under the policy;
7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits;
8) the date a Person requests termination of coverage under the policy, but not prior to the date of request; or
9) the date the Lump Sum Disability Benefit is paid to the Person.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

1) the Actively At Work definition; and
2) the applicable number of hours needed to meet the requirement for full-time Participant, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

SECTION 5C – CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE AND TEMPORARY LAYOFF

LEAVE OF ABSENCE references in this Section means the Person is absent from Active Work for a temporary period of time that has been agreed to in advance and in writing by the Policyholder and includes temporary layoffs unless otherwise stated.

CONTINUATION OF PERSONAL INSURANCE WHILE TEMPORARILY LAID OFF. If the Policyholder approves a temporary layoff, a Person's coverage under the policy will be continued , as long as premiums continue to be paid to and received by AUL, subject to same requirement as a Leave Of Absence.

CONTINUATION OF PERSONAL INSURANCE UNDER A LEAVE OF ABSENCE: If the Policyholder approves a Leave of Absence, a Person's coverage under the policy will be continued to the end of the Coverage Month following the month that a Person begins a Leave of Absence, as long as premiums continue to be paid to and received by AUL, subject to the following requirements:

1) the Policyholder has approved a Person's Leave of Absence in writing;
2) applicable premiums must continue to be paid to AUL in accordance with the policy (see Section 6 - PREMIUM PAYMENT); and
3) the Lump Sum Disability Benefit will be the amount in effect prior to the date the Person's Leave of Absence began.

Continuation of Personal Insurance under this provision will cease on the EARLIEST of the following:

1) the date a Person dies;
2) the date a Person's coverage terminates for nonpayment of premiums;
3) the date a Person begins full or part-time employment with another employer;
4) the date the policy terminates;
5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
6) the date a Person's class is no longer offered under the policy;
7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits;
8) the date a Person requests termination of coverage under the policy, but not prior to the date of request; or
9) the date the Lump Sum Disability Benefit is paid to the Person.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

1) the Actively At Work definition; and
2) the applicable number of hours needed to meet the requirement for full-time Participant, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

SECTION 5D - CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE

LEAVE OF ABSENCE means the Person is absent from Active Work for a temporary period of time that has been agreed to in advance in writing by the Policyholder.

CONTINUATION OF PERSONAL INSURANCE DURING A LEAVE OF ABSENCE FOR ACTIVE MILITARY SERVICE: If the Person is on a leave of absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state law, the Person's coverage may be continued until the later of:

1) the length of time the coverage may be continued under the policy for an FMLA leave of absence; or
2) the length of time the coverage may be continued under the policy for a Leave of Absence other than an FMLA leave of absence.

Coverage continued under this Section is subject to the following requirements:

1) applicable premiums must continue to be paid to and received by AUL in accordance with the policy (see Section 6 – PREMIUM PAYMENT); and
2) the Lump Sum Disability Benefit will be the amount in effect prior to the date the Person's Leave of Absence For Active Military Service began.

Continuation of Personal Insurance under this provision will cease on the earliest of the following:

1) the date a Person dies;
2) the date a Person's coverage terminates for nonpayment of premiums;
3) the date a Person begins full or part-time employment with another employer;
4) the date the policy terminates;
5) the date a Person notifies the Policyholder that he will not be returning to Active Work;
6) the date a Person's class is no longer offered under the policy;
7) the date a Person no longer qualifies for a Leave of Absence or participation in an eligible class, as stated in the Schedule of Benefits;
8) the date a Person requests termination of coverage under the policy, but not prior to the date of request; or
9) the date the Lump Sum Disability Benefit is paid to the person.

All terms and conditions of the policy will apply during the approved continuation period provided under this Section, unless otherwise stated. While Personal Insurance is being continued under this Section, the Person will be considered exempt from the requirements listed below:

1) the Actively At Work definition; and
2) the applicable number of hours needed to meet the requirement for full-time Participant, as stated in the Schedule of Benefits.

If the Policyholder has approved more than one type of Leave of Absence for the Person during any one period, AUL will consider such leaves to be concurrent for the purpose of determining how long the Person's coverage may continue under the policy.

SECTION 6 – PREMIUM PAYMENT

PREMIUM PAYMENTS: As provided in the Application, the Policyholder is responsible for properly and accurately paying premium to AUL on or before the Due Date. All premiums will be calculated and paid in U.S. dollars. At the request of the Policyholder and AUL's written approval, the interval of premium payments may be changed.

Overpayment of premium will not result in increases in any coverage amounts or additional benefits for the Policyholder or Person. If a Person has Contributory Insurance, premiums paid by the Person may be paid by means of payroll deduction administered by the Policyholder.

Premiums for a Person's coverage under the policy shall be owed beginning on the Person's Individual Effective Date of Insurance. Premiums will cease to be owed on the Person's individual termination date. However, premiums will continue to be owed if the Person is Disabled on his individual termination date. Premiums will continue to be owed until the date they are waived according to the Waiver of Premium provision.

Each premium payment will include adjustments in past premiums for changes that have not previously been taken into account. Payment of any premium does not maintain the insurance in force beyond the end of the period for which it has been paid. Each premium payment is owed to AUL on or before its Due Date.

The above manner of charging premiums applies only to a Person's insurance that is terminating, but not the termination of the policy. Each premium payment will include adjustments in past premiums for changes that have not previously been taken into account.

PREMIUM RATES: AUL reserves the right to change premium rates on any date:

1) after the Policyholder's coverage has been in effect for 3 years or as stated in the Application, by giving prior written notice to the Policyholder at least 31 days before the effective date of the change;
2) the eligibility or benefit provisions are changed;
3) the number of Persons insured under the policy changes by 10% or more;
4) a division, unit, subsidiary or affiliate is added to, or deleted from, the Policyholder's coverage under the policy;
5) if the age or any other fact that affects the benefits for a Person or Policyholder has been misstated; or
6) there is a change in existing laws which affects the coverage offered under the policy.

WAIVER OF PREMIUM BENEFIT: *Contributory option:* Premium payments for a Disabled Person will be waived the first Date of Disability and will continue to be waived during the Elimination Period and Benefit Eligibility Period. If a Disabled Person returns to work before the end of his Elimination Period or his Benefit Eligibility Period, his premium payments will resume, but he will not be required to repay the waived premiums.

Premiums for coverage under the policy will be waived as described in this provision, providing the Lump Sum Disability Benefit is paid by AUL.

SECTION 7 - GENERAL POLICY PROVISIONS

AGENCY: For all purposes of the policy, the Policyholder acts on behalf of itself or as agent for the Person. Under no circumstances will the Policyholder be deemed the agent of AUL.

AMENDMENT AND CHANGES: The policy may be amended in writing by mutual agreement between the Policyholder and AUL, but without prejudice to any loss incurred prior to the effective date of the amendment. No change in the policy is valid until approved in writing by the Chief Executive Officer, President, or Secretary of AUL. No agent has the authority to approve coverage, change the policy or waive any of its provisions.

ASSIGNMENT: No assignment of any present or future right or benefit under the policy will bind AUL without its prior written consent and when permitted under applicable laws.

CERTIFICATES: AUL will issue a certificate for delivery by the Policyholder to the insured Persons. The certificate will summarize the Person's coverage under the policy and will state:
1) the benefits provided; and
2) to whom the benefits are payable.

If there is any discrepancy between the provisions of any marketing materials, plan documents, certificate, and the provisions of the policy, the provisions of the policy will govern.

CLERICAL ERROR: Clerical error on the part of the Policyholder or AUL will not invalidate insurance otherwise in force nor continue insurance otherwise terminated.

CONFORMITY WITH STATE LAWS: Any provision of the policy in conflict with the laws of the state in which it is delivered is amended to conform to the minimum requirements of those laws.

DATA AND RECORDS: The Policyholder must promptly furnish all information that AUL reasonably requires. The Policyholder must furnish all relevant information to AUL about Persons:
1) who qualify to become insured or are eligible for benefits;
2) whose amounts of insurance change; and/or
3) whose insurance terminates.

At any reasonable time, AUL or its representatives shall have the right to inspect the records of the Policyholder that, in the opinion of AUL, may have a bearing on the insurance coverage provided under the policy.

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if AUL (or its third party administrator) decides in its discretion that the Person is entitled to them. Except for the functions the policy explicitly reserves to the Policyholder, AUL reserves the right to:
1) manage the policy and administer claims under it; and
2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator) authority includes, but is not limited to, the right to:
1) establish and enforce procedures for administering the policy and claims under it;
2) determine Participants' eligibility for insurance and entitlement to benefits;
3) determine what information AUL reasonably requires to make such decisions; and
4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator.

SECTION 7 - GENERAL POLICY PROVISIONS

ENTIRE CONTRACT: The policy, the application forms of the Persons, the Application of the Policyholder, and any amendments made from time to time constitute the entire contract.

GRACE PERIOD: If the Policyholder or AUL does not give notice in writing that coverage under the policy is to be terminated, a Grace Period of 31 days will be granted for the payment of any premium owed after the first premium Due Date. During the Grace Period, the policy will continue in force but will automatically terminate on the last day of the Grace Period. The Policyholder is liable to AUL for payment of premiums for the days of grace during which the policy remains in force. AUL is not obligated to pay claims incurred during the Grace Period until the premium owed is received.

INSURANCE FRAUD: AUL wants to ensure that its customers do not incur additional insurance costs as a result of the act of insurance fraud. Applicable state laws require AUL to undertake measures to detect, investigate and prosecute fraud.

Anyone that knowingly completes an application for insurance or statement of claim containing any materially false information or facts, with the intent to deceive, conceal or mislead is committing a fraudulent insurance act. This is a crime and may subject that Person to criminal and civil penalties.

MISSTATEMENT OF FACTS: If the age or any other fact that affects the benefits for a Person or Policyholder has been misstated, the benefits will be payable based on the true facts. Premium adjustment will be made so that AUL will receive the actual premium required based on the true facts.

RELATIONSHIP: AUL and the Policyholder are, and will remain, independent contractors. Nothing in the policy or the Application shall be construed as making the parties joint ventures or as creating a relationship of employer and Participant, master and servant or principal and agent. Neither party has any power, right or authority to bind the other or to assume or create any obligation or responsibility on behalf of the other. AUL and the Policyholders each retain exclusive control of their time and methods to perform their respective duties. AUL and the Policyholder will employ, pay and supervise their own employees and pay their own expenses. The Policyholder is required to familiarize itself with all relevant state and federal laws including applicable banking, MEWA, plan sponsor, plan administrator, and fiduciary laws. Any violation of federal or state law will require Policyholder to reimburse AUL for any and all damages or fines imposed on AUL as well as AUL's reasonable attorney's fees incurred due to Policyholder's violations and/or any violations incurred by any representative of Policyholder, in which AUL is made party thereof.

STATEMENTS MADE IN AN APPLICATION: All statements made by the Policyholder, or insured Persons shall be deemed representations and not warranties. No such statements will be used to reduce or deny any claim or to cancel the Person's coverage unless:

1) the statement is in writing; and
2) a copy of that statement is given to the Person or his Survivor.

SECTION 7 - GENERAL POLICY PROVISIONS

INCONTESTABILITY: The validity of any coverage under the policy may not be contested, except in the case of fraud or for nonpayment of premiums, after the policy has been in force for two years after its date of issue, and other than a misrepresentation of a material fact, no statement made by a Policyholder or a Person relating to his insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless: (1) the insurance has not been in force for a period of two years or longer; or (2) the statement is contained in a written instrument signed by the Person. However, AUL is not precluded from asserting at any time any defenses based upon provisions in the policy relating to eligibility for coverage. All statements made by a Policyholder or a Person are to be deemed representations and not warranties, and that other than a misrepresentation of a material fact no statement made by any Person may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the Person or, in the event of death or incapacity of the Person, to the Person's personal representative.

WORKER'S COMPENSATION AND WORKMEN'S COMPENSATION NOT AFFECTED: The policy is not in lieu of, and does not affect any requirement for coverage by Worker's or Workmen's Compensation Insurance.

SECTION 7A - CLAIM PROCEDURES

INITIAL NOTICE OF DISABILITY: Written notice of Disability must be given to AUL within 90 days after the Elimination Period ends. If written notice cannot be made during this time period due to an Act of God or force majeure event, AUL must be notified as soon as it is reasonably possible to do so. Written notice should contain sufficient information to identify the Person. Notices are not considered given until received by AUL at its Home Office in Indianapolis, Indiana or by one of its Claims offices.

CLAIM FORMS FOR PROOF OF LOSS: Upon receipt of the Initial Notice of Disability, AUL will furnish the Policyholder with any necessary claim forms to be given to the Person. These forms must be properly, accurately and truthfully completed and returned to AUL. If, for any reason, the Person does not receive a claim form within 15 days of request, the Person should submit written proof of Disability. The initial claim form or proof of Disability must show:

1) claimant's name;
2) Employer's name and address;
3) Policy number;
4) the date Disability started;
5) the cause of Disability; and
6) the nature and extent of the Disability.

The initial claim form or proof of Disability must be signed by a Physician and sent to AUL within 90 calendar days of the Benefit Eligibility Period. If it is not possible to give proof within these limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than six (6) months after the time proof is otherwise required.

AUL will also periodically send the Person additional claim forms or requests for information necessary to determine eligibility for benefits under the policy. These subsequent claim forms and requests for information must be returned to AUL within 30 days after the Person receives them.

LEGAL ACTION: No legal action may be brought to obtain benefits or a refund of premium paid under the policy:

1) for at least 60 days after proof of loss or entitlement to a premium refund has been furnished; or
2) before any denial or reduction of benefits by AUL has been appealed properly in writing; or
3) no action may be brought after three (3) years following the expiration of the time within which proof of loss or entitlement to a premium refund is required by the Policyholder.

TIME OF PAYMENT OF CLAIMS: When AUL receives a claim form or proof of Disability, benefits for which AUL is liable under the policy will be paid.

PAYMENT OF CLAIMS: All benefits are payable to a Person. If a Person dies before a benefit to which he was entitled is paid, AUL has the right to pay the Survivor. If AUL pays benefits in good faith to a person who it considers entitled to such benefits or without notice of closer kinship, then AUL will have no obligation to pay such benefits again. The Lump Sum Disability Benefit Amount will be calculated and paid in United States dollars. All claim payments will be made in compliance with ERISA or in accordance with applicable state laws.

RIGHT TO APPEAL: If a Person wishes to appeal AUL's decision, claimants are allowed 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination. Claimants are allowed the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of 29 C.F.R. § 2560.503-1. AUL's review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. A claimant has a right to obtain the information about any voluntary appeal procedures offered by the plan described in paragraph (c)(3)(iv) of 29 C.F.R. § 2560.503-1 and has a right to bring an action under section 502(a) of ERISA. A final determination will be provided pursuant to 29 C.F.R. § 2560.503-1.

ARBITRATION: Any controversy or claim arising out of or relating to the policy, the sale or solicitation of the policy, or its breach thereof whether in tort, contract, breach of duty (including but not limited to) any alleged fiduciary, good faith and fair dealing duties, shall be decided by arbitration in accordance with the Federal Arbitration Act, the procedures of the commercial arbitration rules of the American Arbitration Association, and this agreement. The Court of Arbitrators, which is to be held in the county seat where the Person resides, shall consist of three (3) arbitrators familiar with employee welfare benefit plans. The selection of the arbitrators shall be conducted within thirty (30) days after proper service of a demand for arbitration. One of the arbitrators shall be appointed by AUL, one by the insured, and the third shall be selected by the first two appointees prior to the beginning of arbitration. Should the two arbitrators be unable to agree upon the choice of a third, the appointment shall be left to the President or any Vice President of the American Arbitration Association. The arbitrators shall decide by a majority of votes, the award shall be in writing, the decision shall be signed by a majority of the arbitrators, and they shall include a statement regarding the reasons for the disposition of any claim. Judgment on the award rendered by the arbitrators may be entered by any court having jurisdiction thereof. The parties are not precluded from challenging the decision under the Federal Arbitration Act or applicable law. Unless not allowed under applicable law, each party shall bear the expense of its own attorney and arbitrator, and shall share equally with the other party the expenses of the third arbitrator and of the arbitration.

The parties agree that AUL is engaged in interstate commerce, and the transaction is governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Consistent with the expedited nature of arbitration, each party will, upon the written request of the other party, promptly provide the other with copies of documents relevant to the issues raised by any claim or counterclaim on which the producing party may rely in support of or in opposition to any claim or defense. Any dispute regarding discovery, or the relevance or scope thereof, shall be determined by the arbitrator(s), which determination shall be conclusive. All discovery shall be completed within sixty (60) days following the appointment of the arbitrator(s) or longer following mutual agreement by the parties.

RIGHT OF RECOVERY: If benefits have been received for which the Person was not entitled to receive under the policy, then full reimbursement to AUL is required. Such reimbursement is required whether the overpayment is due to intentional or innocent misrepresentations by the Person, intentional or innocent misrepresentations by an entity supplying AUL with information, a claims processing error or miscalculation by AUL or for any other reason. If reimbursement is not made, then AUL has the right, as allowed under law to:

1) reduce future benefits or any amounts payable under all other AUL insurance contracts insuring the Person until full reimbursement is made, and
2) recover such overpayments from the Person or his estate.

If AUL chooses not to use benefit payments towards the reimbursement, this will not constitute a waiver of AUL's rights to reimbursement. This provision will be in addition to, and not in lieu of, any other compensation available to AUL by law.

SECTION 8 - INSURING PROVISIONS

LUMP SUM DISABILITY BENEFIT: AUL will pay a Lump Sum Disability Benefit to the Person according to the terms of the policy if, while insured under the policy, a Person:

1) satisfies the Elimination Period;
2) becomes Permanently and Totally Disabled during the Benefit Eligibility Period; and
3) submits the required proof that he is Permanently and Totally Disabled within 90 days of the end of the Benefit Eligibility Period.

The Lump Sum Disability Benefit Amount shown in the Schedule of Benefits is payable to the Person once and will be subject to Reductions and other provisions of the policy.

The Lump Sum Disability Benefit Amount will never exceed the Maximum Lump Sum Disability Benefit Amount stated in the Schedule of Benefits.

PHYSICAL EXAMINATION: AUL, at its own expense, has the right to have a Person examined and evaluated to determine the existence of and basis for any Disability. This right may be exercised as often as is reasonably necessary, as determined by AUL, and must be performed by a Physician of AUL's choice.

The Lump Sum Disability Benefit will NOT be payable if:

1) the Person dies during the Elimination Period;
2) the Person becomes Permanently and Totally Disabled after the last day of the Benefit Eligibility Period;
3) the Person is working;
4) the Person fails to submit the required claim forms for proof of loss within 90 days of the Benefit Eligibility Period;
5) the Person refuses to allow an examination requested by AUL;
6) the Person is no longer under the Regular Attendance and care of a Physician;
7) the date a Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been residing outside the United States or Canada during the Elimination Period or Benefit Eligibility Period; or
8) the Person has already been paid a Lump Sum Disability Benefit under the policy.

RECURRENT RETURN TO WORK PERIOD: As long as the Policyholder’s coverage remains in force with AUL, if a Person resumes his Regular Occupation for the Policyholder on a full-time basis, and performs each Material and Substantial Duty of that occupation for less than the Return to Work Period during the Benefit Eligibility Period (both of which are shown on the Schedule of Benefits), the Disability will be part of the prior period of Disability. Days the Person returns to work for the same Policyholder will not extend the Benefit Eligibility Period. The Disability must be the direct result of the Injury or Sickness that caused the prior Disability. A Person will not have to complete a new Elimination Period. The Lump Sum Disability Benefit will be subject to the terms of the policy for the prior Disability.

If, after the period of Disability as stated in the preceding paragraph, a Person resumes his Regular Occupation for the Policyholder on a full-time basis for more than the return to work period as shown on the Schedule of Benefits, any further Disability will be part of a new period of Disability and a new Elimination Period must be completed before a Person may qualify for a Lump Sum Disability Benefit.

ACCUMULATION OF ELIMINATION PERIOD: If a Person satisfies the number of days in the Elimination Period within a period of time that is two times the Elimination Period, then that Disability will be treated as continuous as long as the Policyholder’s coverage remains in force with AUL.

SECTION 8 – INSURING PROVISIONS

DEATH OF A PERSON: If a Person dies after qualifying for, but before receiving, the Lump Sum Disability Benefit, the full Lump Sum Disability Benefit Amount will be payable to the Person's Survivor.

10% of the Lump Sum Disability Benefit Amount owed after applicable Reductions may be paid to the Survivor if:

1) prior to his death, the Person had satisfied the Elimination Period;
2) prior to his death the Person was Disabled;
3) the Person died during the Benefit Eligibility Period but before satisfying the conditions of Permanent and Total Disability; and
4) the Person's death due to complications or was caused by the Person's Disability.

All the General Exclusions pertaining to a Disability listed in Section 9 - EXCLUSIONS would apply.

SECTION 9 - EXCLUSIONS

GENERAL EXCLUSIONS: The policy does not cover any Disability or provide any benefits for a loss caused by, contributed to by, or resulting from:

1) participation in war or any act of war, declared or undeclared;
2) active participation in a riot;
3) attempted suicide, regardless of mental capacity;
4) attempted or actual self-inflicted bodily injury or self destruction, including but not limited to the voluntary inhaling or taking of:
   a) a prescription drug in a manner other than as prescribed by a Physician;
   b) any federal or state regulated substance in an unlawful manner;
   c) non-prescription medicine in a manner other than as indicated in the printed instructions;
   d) poison; and
   e) toxic fumes;
5) commission of or attempt to commit a criminal act under relevant state law;
6) Cosmetic Surgery. However, Cosmetic Surgery will be covered when it is due to:
   a) reconstructive surgery incidental to, or follows surgery resulting from, trauma, infection or other diseases of the involved part; or
   b) congenital disease or anomaly that has resulted in a functional defect;
7) a Person being legally intoxicated as defined by the law of the jurisdiction in which the incident occurs;
8) any event that occurs while a Person is incarcerated in a penal or correctional institution;
9) participation in voluntary asphyxiation;
10) traveling or flying on any aircraft being used for experimental purposes; or
11) engaging in any illegal or fraudulent activity, work, or employment.

PRE-EXISTING CONDITION EXCLUSION:
Benefits will not be paid if the Person's Disability begins in the first 12 months following the Person's Individual Effective Date of Insurance; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to the Person's Individual Effective Date of Insurance.

SECTION 9 - EXCLUSIONS

PRE-EXISTING CONDITION EXCLUSION ON AN INCREASED BENEFIT OR GUARANTEED INCREASE IN BENEFIT: This provision applies to an increase in Lump Sum Disability Benefit Amount that occurs after the Policyholder's Effective Date.

The policy will not cover the amount of the increase in Lump Sum Disability Benefit Amount if the Person's Disability begins in the first 12 months following the effective date of the increase in coverage; and the Person's Disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which the Person received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the three (3) months just prior to his effective date of increase in amount of insurance.

SECTION 10 - LIMITATIONS

DRUG AND ALCOHOL ABUSE LIMITATION: The Lump Sum Disability Benefit for a Person who is Permanently and Totally Disabled due to drug and alcohol abuse or a condition caused by or contributed to by drug and alcohol abuse, will be limited to 20% of the Lump Sum Disability Amount after applicable Reductions.

MENTAL ILLNESS LIMITATION: The Lump Sum Disability Benefit for a Person who is Permanently and Totally Disabled due to mental illness, will be limited to 20% of the Lump Sum Disability Amount after applicable Reductions. AUL will not apply the Mental Illness Limitation to a Disability due to dementia if it is a result of:

1) stroke;
2) trauma;
3) viral infection; or
4) Alzheimer's disease.

SPECIAL CONDITIONS LIMITATION: Lump Sum Disability Benefit for a Person who is Permanently and Totally Disabled due to a Special Condition, will be limited to 20% of the Lump Sum Disability Amount after applicable Reductions.

SPECIAL CONDITION means:

1) musculoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of joints and adjacent muscles, EXCEPT:
   a) arthritis;
   b) herniated intervertebral discs;
   c) scoliosis;
   d) spinal fractures;
   e) osteopathies;
   f) spinal tumors, malignancy, or vascular malformations;
   g) radiculopathies;
   h) spondylolisthesis, grade II or higher;
   i) myelopathies and myelitis;
   j) demyelinating disease;
   k) traumatic spinal cord neurosis;
   l) myofacial pain syndrome;
2) chronic fatigue syndrome;
3) fibromyalgia;
4) carpal tunnel syndrome; or
5) environmental allergic illness, including but not limited to sick building syndrome and multiple chemical sensitivity.

SECTION 12 - PORTABILITY PRIVILEGE

If a Person's insurance under the policy terminates for any reason other than stated below, the Person is entitled to continue his coverage for 12 months without submission of Evidence Of Insurability. To be eligible for this Privilege, the Person must have been insured under the policy for at least 12 consecutive months immediately preceding the Person's individual termination.

This Portability Privilege provides a Lump Sum Disability Benefit Amount equal to 50% of the coverage the Person had immediately prior to the date of his termination. Any benefits payable under this Section are governed according to the provisions of the policy.

This Portability Privilege is subject to the following:

1) written application for Portability must be made within 31 calendar days after termination of insurance under the policy;
2) payment of the amount of premium owed;
3) the premium is based on the Person's age and the premium rate in effect on the date of application for Portability; and
4) the effective date for the Person under the Portability Privilege is the date immediately following the date of his termination.

The Portability Privilege is not available to any Person:

1) whose insurance under the policy terminates for any of the following reasons:
   a) the Person enters a class of Participants that are not eligible for coverage under the policy;
   b) the Person retires (including, but not limited to, when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career); or
   c) the Person fails to pay any required premiums;
   d) the Person was paid a Lump Sum Disability Benefit;
2) who is or becomes insured for any other coverage similar to the type of coverage provided by the policy within 31 days after termination under the policy;
3) who is Disabled under the terms of the policy; or
4) who is on Leave of Absence.

Insurance under the Portability Privilege will terminate on the earliest of the following dates:

1) the last day for which any required premium has been made;
2) the date the Person requests termination, but not prior to the date of the request;
3) the last day of a Coverage Month, provided that AUL has given at least 31 days prior written notice to the Person;
4) the date the Person retires;
5) the date the policy terminates;
6) the date the Person enters active military service for any country, except for temporary duty of 30 days or less;
7) the date that coverage begins under any other insurance policy that provides coverage similar to coverage provided by the policy;
8) the date following 12 months of coverage;
9) the date the Lump Sum Disability Benefit is paid to the Person; or
10) the date a Person leaves the United States or Canada and establishes his residence in any other country. A Person will be considered to reside outside these countries when the Person has been residing outside the United States or Canada during the Elimination Period or Benefit Eligibility Period.

Notice Concerning Coverage Limitations and Exclusions under the Ohio Life and Health Insurance Guaranty Association Act

Residents of Ohio who purchased life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Guaranty Association in selecting an insurance company or in selecting any insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, OH 43220

Ohio Department of Insurance
50 West Town Street
Third Floor - Suite 300
Columbus, OH 43215

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
2) the insurer was not authorized to do business in this state;
3) their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2) any policy of reinsurance (unless an assumption certificate was issued);
3) interest rate yields that exceed an average rate;
4) dividends;
5) credits given in connection with the administration of a policy by a group contract holder;
6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees of other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under Section 401, 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.