FORT DEARBORN LIFE INSURANCE COMPANY

(A stock life insurance company herein called "We," "Us," "Our")
Chicago, Illinois

Administrative Office:

2400 Lakeside Blvd., Richardson, TX. 75082.7399

Issues this Group Insurance Policy (TX) to:

POLICYHOLDER NAME: **Sunland Engineering Co., dba Sunland Corp**

GROUP POLICY NUMBER: GFZ3539-0001

EFFECTIVE DATE: 01/01/2006

INITIAL PREMIUM RATES: See attached Rate Addendum

This Policy is delivered in the State of Texas and is subject to the laws of that jurisdiction.

This Policy is issued in consideration of the Application of the Policyholder, a copy of which is attached, and of the payment of premiums by the Policyholder when due. We will pay benefits under the terms of this Policy in accordance with its provisions.

The first anniversary occurs on 01/01/2008 and all future anniversaries in twelve month intervals.

IN WITNESS WHEREOF, Fort Dearborn Life Insurance Company has caused this Policy to be executed at its home office in Chicago, Illinois.

President

Secretary

Death Benefits will be reduced if an accelerated death benefit is paid.

DISCLOSURE: The Accelerated Death Benefit offered under this Policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Death Benefit qualifies for such favorable tax treatment, the benefits will be excluded from the insured Employee's income and not subject to federal taxation. Tax laws relating to Accelerated Death benefits are complex. The insured Employee is advised to consult with a qualified tax advisor about circumstances under which he or she could receive the Accelerated Death benefit excludable from income under federal law.

Receipt of the Accelerated Death Benefit payment may affect the insured Employee, his or her spouse, or his or her family's eligibility for public assistance such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. The insured Employee is advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect the insured Employee, his or her spouse, or his or her family's eligibility for public assistance.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSE THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THIS IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND FORT DEARBORN

PLEASE READ CAREFULLY

NON-PARTICIPATING
GROUP TERM LIFE INSURANCE POLICY
Accelerated Death Benefits
AD&D Benefits

*** IMPORTANT NOTICE ***

To obtain information or make a complaint:

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

1-800-778–2281

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

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

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

*** AVISO IMPORTANTE ***

Para informacion o para someter una queja:

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

1-800-778–2281

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

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

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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the *Texas Insurance Code,* Article 21.28-D.) BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT S POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are: residents of Texas at the time that their insurance company is impaired and residents of other states**,** ONLY if the following conditions are met:

1) The policyholder has a policy with a company based in Texas;
2) The company has never held a license in the policyholder's state of residence;
3) The policyholder's state of residence has a similar guaranty association;
4) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:
- up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance:
- net cash surrender value up to a total of $100,000 under one or more policies on any one life; or
- death benefits up to a total of $300,000 under one or more policies on any one life.

Individual Annuities:
- net cash surrender amount up to a total of $100,000 under one or more policies owned by one contractholder.

Group Annuities:
- net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contractholder.
- net cash surrender amount up $5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE. WHEN YOU ARE SELECTING AN INSURANCE COMPANY, YOU SHOULD NOT RELY ON COVERAGE BY THE ASSOCIATION.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
301 Congress, Suite 500
Austin, Texas 78701
800-982-6362

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439

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DEFINITIONS (TX)

This section tells You the meaning of special words and phrases used in this Policy. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or **Accidental** means a sudden, unexpected event that was not reasonably foreseeable.

Actively at Work or **Active Work** means that an Employee is:

1. performing the normal duties of his occupation; and
2. working the number of hours set forth in the Application.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied. The Application is attached to and forms a part of this Policy, and shall include any subsequent amendments to the Application.

Base Annual Salary means the gross annual compensation prior to before-tax payroll deductions, if any, which an Insured earns from his occupation with the Policyholder.

It does not include Salary from overtime, bonuses or any other form of extra pay. However, if an Employee's Salary is based in whole or in part on commissions, Base Annual Salary will include the amount paid in commissions during the preceding twelve-month calendar period. An Employee's deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross annual compensation.

Increases to Base Annual Salary which result in a benefit increase of $50,000 or greater and are above the guarantee issue amount will be subject to evidence of insurability satisfactory to Us before the increased benefit can become effective. Receipt of premium before we have approved any evidence of insurability will not constitute acceptance and does not guarantee issuance of any benefit amount prior to our approval.

Basic Weekly Wage means the gross weekly compensation prior to before-tax payroll deductions, if any, which an Insured earns from his occupation with the Policyholder.

It does not include compensation from overtime, bonuses or any other form of extra pay. However, if an Employee's compensation is based in whole or in part on commissions, Basic Weekly Wage will include the weekly average paid in commissions during the preceding twelve-month calendar period. An Employee's deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross weekly compensation.

Base Annual Salary/**Basic Weekly Wage** for each Insured who is a partner means the Insured's annual/average weekly compensation from the partnership during the calendar year prior to the date of the Insured's loss, as reported on the partnership federal income tax return as the "net Salary (loss) from self-employment" for that year.

If an Insured was not a partner during the calendar year prior to the date of loss, Base Annual Salary/Basic Weekly Wage means the Insured's annual/average weekly compensation (excluding dividends, capital gains, and return of capital) from the partnership prior to the date of the Insured's loss, determined in accordance with the terms of the applicable partnership agreement. In the event of a disagreement between Us and the claimant, an adjustment will be made, if warranted, after the Insured's subsequent federal income tax return is submitted to Us.

No benefits are payable when any of the above calculations result in an amount less than zero.

Base Annual Salary/Basic Weekly Wage for each Insured who is a sole proprietor or shareholder in a Subchapter S Corporation or a member in a limited liability company means the Insured's annual/average weekly net taxable income (excluding dividends, capital gains, and return of capital) derived from the Policyholder for the calendar year prior to the date of the Insured's loss, as reported on his federal income tax return. The Insured's annual/average weekly net taxable income equals A minus B, where:

A = The Insured's annual/average weekly taxable income derived from the Policyholder for the prior calendar year (excluding dividends, capital gains, and return of capital), as reported on the Insured's federal income tax return; and

B = The Insured's annual/average weekly deductible work expenses attributable to his work for the Policyholder during the prior calendar year, as reported on the Insured's federal income tax return.

If an Insured was not a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company during the calendar year prior to the date of the Insured's loss, Base Annual Salary/Basic Weekly Wage means an Insured's annual/average weekly net taxable income derived from the Policyholder for the period he was a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company prior to the date of the Insured's loss. The Insured's annual/average weekly net taxable income will be based on the taxable income derived from the Policyholder for the period of the Insured's work as a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company for the Policyholder, taking into account his deductible work expenses attributable to his work for the Policyholder during the same period.

No benefits are payable when any of the above calculations result in an amount less than zero.

Contributory means the Insureds pay a portion of the premium for this insurance coverage.

Employee means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Injury means bodily injury resulting directly from an Accident and independently of all other causes.

Insured means an Employee covered under this Policy.

Male Pronoun whenever used includes the female.

Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Policy means this contract between the Policyholder and Us including the attached Application, which provides group insurance benefits.

Policyholder means the person, firm, or institution named on the face of this Policy.

Total Disability or **Totally Disabled** under the Waiver of Premium provision means an Insured is completely unable to engage in any occupation for wage or profit because of Sickness or Injury.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

ELIGIBILITY

All Employees who belong to an eligible class and work the minimum number of hours as set forth in the Application are eligible for group insurance. An Employee must be **Actively at Work** for his insurance coverage to become effective.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Noncontributory Benefits)

An Employee who is Actively at Work will become insured for Noncontributory benefits under this Policy on the day following completion of the Employee waiting period, if any, set forth in the Application.

If an Employee waives all or a portion of his Noncontributory coverage and chooses to enroll at a later date, the Employee is considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Contributory Benefits)

An Employee may apply for Contributory insurance coverage at any time. His coverage will become effective as follows, provided he is Actively at Work on that date:

1. If the enrollment form is signed on or before the end of the waiting period, if any, as stated in the Application, the coverage will become effective on the day following completion of the waiting period.
2. If the enrollment form is signed after the end of the waiting period, but within 31 days after that day, the coverage will become effective the date the Employee signs the enrollment form.
3. If the enrollment form is signed following this 31-day period, the Employee is considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

DEFERRED EFFECTIVE DATE

An Employee must be Actively at Work on the date his initial coverage or any increases in coverage are scheduled to begin. If:

1. he is absent from Active Work on the date such coverage would otherwise become effective; and
2. his absence is caused by an injury, illness or layoff,

the effective date of any initial coverage or increased coverage will be deferred until the first day he returns to Active Work. An Employee will be considered Actively at Work if he was actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

EFFECTIVE DATE IF WE REQUIRE EVIDENCE OF INSURABILITY

If an Employee is required to submit evidence of insurability satisfactory to Fort Dearborn Life Insurance Company, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EFFECTIVE DATE OF CHANGES IN AMOUNT OF BENEFIT

Any change in the amount of an Insured's benefits caused by a change in class, change in salary, age reduction or amendment to the Policy will become effective on the effective date of the change. If the change results in an increase in the amount of insurance, the Insured must be Actively at Work on that date. If the Insured is not Actively at Work, the increase will take effect on the day he is again Actively at Work.

ELIGIBILITY AFTER TERMINATION OF EMPLOYMENT

If an Employee's coverage ends due to termination of employment he must meet all the requirements of a new Employee if he is rehired at a later date.

GROUP TERM LIFE INSURANCE BENEFIT (TX)

BENEFIT

We will pay an Insured's beneficiary the amount of life insurance in force as of the date of the Insured's death provided:

1. he is insured under this Policy on the date of death, and
2. We receive proof of death.

We will determine the amount of insurance payable based upon the attached Application.

BENEFICIARY

Each Insured's beneficiary designation must be made on a form which We provide or on a form accepted by Us. If two or more beneficiaries are named, payment of proceeds will be apportioned equally unless the Insured had specified otherwise. The Policyholder may not be named as beneficiary.

Unless otherwise provided by an Insured, if a beneficiary dies before the Insured, We will divide that beneficiary's share equally between any remaining named beneficiaries.

If no named beneficiary survives the Insured or if no beneficiary is designated by the Insured, We will pay the amount of insurance:

1. to the Insured's spouse, if living; if not,
2. in equal shares to the then living natural or adopted children of the Insured, if any; if none,
3. in equal shares to the father and mother of the Insured, if living; if not,
4. to the estate of the Insured.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

If any benefits under this provision are to be paid to the estate of an Insured, We may pay an amount not greater than $250 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to the Insured's death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

CHANGE OF BENEFICIARY

An Insured may change his beneficiary at any time by completing a change request form, or a form accepted by Us, and sending it to the Policyholder. The Insured's written request for change of beneficiary will not be effective until it is recorded by the Policyholder. After it has been so recorded, it will take effect on the later of the date the Insured signed the change request form or the date he specifically requested. If the Insured dies before the change has been recorded, We will not alter any payment that We have already made. Any prior payment shall fully discharge Us from further liability in that amount.

CONVERSION OF LIFE INSURANCE

Conversion if Eligibility Terminates:

An Insured may convert to an individual policy of life insurance if his life insurance, or a portion of it, ceases because:

1. he is no longer employed by the Policyholder; or
2. he is no longer in a class which is eligible for life insurance.

In either of these situations, he may convert all or any portion of his life insurance which was in force at the date of termination.

Conversion if Policy is Terminated or Amended:

An Insured may also convert to an individual policy of life insurance if his life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making him ineligible for life insurance; however, in either of these situations,

he must have been insured under the Policy for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which the Insured becomes eligible under this or any other group policy within 31days after the date his life insurance ceased; or
2. $10,000.

Conditions for Conversion: (amended by form no. FDL1-23-1100)

We must receive written application and the first premium for the individual life insurance policy within 31 days after insurance under the Policy ceases. No evidence of insurability will be required.

The individual policy will be a policy of whole life insurance. It will not contain disability benefits, accidental death and dismemberment benefits or any other supplemental benefits.

The premium for the individual policy will be based on:

1. Our current rates based upon the applicant's attained age on his nearest birthday; and
2. on the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which the applicant could apply for conversion.

If the Insured dies during a period when he would have been entitled to have an individual policy issued to him and if he dies before such an individual policy became effective, We will pay the beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. the death occurred during the 31-day period within which he could have made application; and
2. We receive proof of death.

If life insurance benefits are paid under this Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

WAIVER OF PREMIUM

We will continue an Insured's life insurance benefit under this Policy without the further payment of life insurance premium if he becomes Totally Disabled, provided:

1. he is insured under this Policy and is Actively at Work on or after the effective date of the Policy; and

2. he is under the age of 60; and

3. he provides Us with satisfactory written proof of Total Disability within 12 months after the date he became Totally Disabled; and

4. his Total Disability has continued without interruption for at least 6 months; and

5. he is still Totally Disabled when he submits the proof of disability; and

6. all required premium has been paid.

The premium will be waived from the date We receive satisfactory written proof of Total Disability. Premium will continue to be waived provided the Insured:

1. remains Totally Disabled; and

2. provides satisfactory written proof of continuing Total Disability upon request, but not more frequently than once every 3 months.

The Insured is responsible for obtaining initial and continuing proof of Total Disability.

The Insured will be covered for the amount of life insurance in force as of the date Total Disability commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as a result of age or amendment to the Policy. This life insurance coverage will continue without the payment of premium until the Insured is no longer Totally Disabled or reaches age 65, whichever occurs first.

We may have the Insured examined at reasonable intervals during the period of claimed Total Disability, but not more frequently than once every three months during the first two years of Total Disability, and not more frequently than once a year after the Insured has been Totally Disabled for two years. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if the Insured refuses to be examined as and when required.

We will pay the amount of life insurance in force to the beneficiary if an Insured dies before furnishing satisfactory proof of his Total Disability, provided:

1. the Insured dies within one year from the date he became Totally Disabled; and

2. We receive proof that the Insured was continuously Totally Disabled until the date of death; and

3. We receive proof of death.

If continuation of life insurance under the Waiver of Premium provision ceases, and the Insured is employed by the Policyholder, his life insurance will continue provided premium payments begin on the next premium due date.

If continuation of life insurance under the Waiver of Premium provision ceases, and the Insured is no longer employed by the Policyholder, he may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of this Policy.

ACCELERATED DEATH - TERMINAL ILLNESS BENEFIT (TX)

ELIGIBILITY

This benefit only applies to Insureds with life insurance benefit amounts of $15,000 or more.

Coverage under the Accelerated Death - Terminal Illness Benefit is subject to the Deferred Effective Date provision. An Insured must be Actively at Work on the date his coverage under this benefit becomes effective. If he is not Actively at Work, the effective date of this coverage will be deferred until the first day he returns to Active Work.

DEFINITIONS

Accelerated Death Benefit means 50% of the Terminally Ill Insured's Group Term Life Insurance amount in force on the date that We receive due proof of loss as described in this provision.

Physician means a licensed practitioner, practicing within the scope of his license. A Physician must be someone other than the Insured or his family member.

Physician's Statement means a written medical opinion of a Physician currently licensed to practice medicine in the United States which:

1. is made at the Insured's expense; and
2. indicates that the Insured has a terminal condition; and
3. includes all medical test results, laboratory reports, and any other information on which the medical opinion is based; and
4. indicates the Insured's expected remaining life span; and
5. is acceptable to Us.

Terminally Ill Insured means an Insured has a non-correctable health condition that, with reasonable medical certainty, will result in death of the Insured within 12 months from the date of the Physician's Statement.

BENEFIT PAYMENT

We will pay an Accelerated Death Benefit during the lifetime of a Terminally Ill Insured if he or his legal representative elects an Accelerated Death benefit and provides due proof of loss as described in this provision. The Accelerated Death Benefit is limited to a maximum of $150,000 and a minimum of $7,500, and is payable only once to any one Insured. There is no cost for an Accelerated Death benefit.

If the Insured's group term life insurance will reduce, due to age, within 12 months after the date We receive proof, the benefit will be 50% of the reduced group term life insurance benefit.

At the time of the payment of the Accelerated Death Benefit, We will send a statement to the certificate holder specifying the amount of benefits paid, the effect of the Accelerated Death Benefit payment on the death benefit face amount; and the amount of benefits remaining available for acceleration.

This benefit does not apply to Accidental Death and Dismemberment benefits.

EXCEPTIONS

The benefit will not be payable:

1. for any amount of group term life insurance which is less than $15,000; or
2. if the Insured becomes Terminally Ill as a result of:
    a. attempted suicide, while sane or insane; or
    b. self-inflicted injury; or
3. if the Insured's group term life insurance benefit has been assigned; or
4. if the Insured's group term life insurance benefit is payable to an irrevocable beneficiary, including notification to Us that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement.

NOTICE AND PROOF OF CLAIM

The Insured must elect the benefit in writing on a form that is acceptable to Us. The Insured must furnish proof that he is a Terminally Ill Insured, including a Physician's Statement, within 91 days of the notice of claim. If proof is not given within 91 days, the claim will not be reduced or denied if proof is given as soon as reasonably possible.

EFFECT ON INSURANCE

When the Accelerated Death Benefit is paid:

1. the amount of group term life insurance otherwise payable upon the Insured's death, is reduced by the amount of the Accelerated Death Benefit. Any portion of the death benefit remaining after the reduction of the death benefit due to payment of an Accelerated Death Benefit shall be paid upon the death of the Insured;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of Accelerated Death Benefit; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the amount of the Accelerated Death Benefit.

The payment of an Accelerated Death Benefit and the balance of the death benefit under this Policy shall constitute full settlement of the face amount of the Policy.

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT (TX)

BENEFIT

We will pay up to the Principal Sum set forth in the Application if an Insured loses his life or a member of his body as a result of an Accident, while insured under this Policy. The amount payable is shown in the table below. The loss must occur within 365 days of the Accident; and the loss must be the direct and sole result of the Accident and independent of all other causes.

Table of Losses:

Principal Sum for Loss of:	One-half of the Principal Sum for Loss of:
Life	Sight of One Eye
Both Hands	One Hand
Both Feet	One Foot
One Hand and One Foot	
Sight of Both Eyes	
One Hand and the Sight of One Eye	
One Foot and the Sight of One Eye	

With respect to hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to sight, Loss means entire and irrecoverable loss of sight.

The total amount of benefits payable for all losses to any one person resulting from any one Accident will not be greater than the Principal Sum set forth in the Application.

We will pay benefits for loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other losses will be paid to the Insured.

SEAT BELT BENEFIT

We will pay an additional benefit of the lesser of the Insured's Principal Sum or $25,000. We will pay this benefit if the Insured suffers loss of life as the result of a covered accident which occurs while he is driving or riding in an Automobile, if:

1. the Automobile is equipped with Seat Belts;
2. the Seat Belt was in actual use and properly fastened at the time of the Accident; and
3. the position of the Seat Belt is certified in the official report of the accident or by the investigating officer. A copy of the police accident report must be submitted with the claim.

If such certification is not available, and it is unclear whether the Insured was properly wearing Seat Belt(s), then We will pay a fixed benefit of $1,000.

Automobile means a validly registered four-wheel passenger car (including Policyholder-owned cars), station wagons, jeeps, pick-up trucks, and van-type vehicles.

Seat Belt means those belts that form an occupant restraint system.

LIMITATIONS

We will not pay any benefits for a loss caused by or connected with:

1. suicide or attempted suicide;
2. intentionally self-inflicted injury, including but not limited to Russian roulette;
3. bodily or mental disease or treatment of these;
4. the Insured's participation in, or as a result of his having participated in the commission of an assault or felony;
5. bacterial infection except pyogenic infection which occurs through or with an Accidental cut or wound;
6. war or any act of war, whether declared or undeclared;
7. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft;
8. the Insured's being under the influence of any drug, (except those prescribed by a physician and used in the manner prescribed), including narcotics, hallucinogens and gas or fumes, which are taken or inhaled voluntarily;
9. voluntary poisoning; or
10. the Insured's being Intoxicated. A concentration of 0.10% or more by weight of alcohol in the blood is conclusive proof that the Insured is Intoxicated.

NOTICE OF CLAIM

If an Insured incurs a loss that may result in a claim for benefits under this Policy, written notice must be given to Us at Our administrative office. This must be done within 20 days after the covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice must contain enough information to identify the claimant.

CLAIM FORMS

When We receive written notice of a claim, We will send the claimant forms with which to file proof of loss. If these forms are not given to the claimant within 15 days, he will be excused from filing the forms provided he sends Us written proof of loss detailing the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS

We must receive written proof of loss within 91 days after the date of the loss for which claim was made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof of loss within 91 days will not invalidate or reduce any claim.

However, except in the absence of legal capacity, proof of loss must be furnished no later than one (1) year from the date such proof is required.

PHYSICAL EXAMINATION

We have the right and opportunity to examine the person of an Insured when and so often as it may be reasonably necessary during the pendency of a claim under this Policy, but not more frequently than once every 3 months.

LEGAL ACTION

No action at law or in equity may begin prior to 60 days after We receive valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

PREMIUM PROVISIONS (TX)

We will charge the rates set forth on the face page of this Policy until the first anniversary of this Policy. However, these rates may be changed on any premium due date if Policy provisions or benefits are changed.

Following the first Policy Anniversary, We may change the rates on any premium due date, but not more than once in any 12-month period. We will notify the Policyholder in writing at least 60 days prior to a change in rates.

PAYMENT OF PREMIUMS

The first premium is due on the Policy effective date. Subsequent premiums are due on the premium due dates set forth in the Application.

Premium charges for new Insureds, for increases in insurance amounts, or for the addition of Dependent or any Supplemental coverage will begin on the premium due date which coincides with or next follows the date of the add or the change. Premium charges for terminated Employees, decreases in insurance amounts, or termination of Dependent or Supplemental coverage will end on the premium due date which coincides with or next follows the termination or the change in amount.

This method of charging premium will neither commence any insurance after the date it would otherwise begin nor extend any insurance coverage beyond the date it would otherwise terminate pursuant to the applicable eligibility or termination provisions of this Policy.

GRACE PERIOD

We will allow a grace period of 31 days for the payment of any premiums due except the first. Insurance coverage shall continue in force during the grace period unless the Policyholder has given Us advance written notice of cancellation in accordance with the terms of this Policy. If premium is not received by the end of the grace period, this Policy will terminate as of the last date for which premium was paid.

The Policyholder is liable for premium due on coverage provided during the grace period.

If We receive written notice during the grace period that the Policy is to be canceled, We will cancel it as of the later of:

1. the date requested in the cancellation notice; or
2. the date We receive such notice. The Policyholder must pay a pro rata premium for any coverage provided during the grace period.

NONPARTICIPATING

This Policy does not share in the earnings of the company.

TERMINATION PROVISIONS (TX)

TERMINATION OF EMPLOYEE COVERAGE

Insurance coverage will end for an Insured on the earliest of:

1. the date the Insured is no longer a member of a covered class; or
2. the date the Policy is canceled; or
3. the effective date of an amendment to this Policy which terminates insurance for the class to which the Insured belongs; or
4. the date the Insured stops making any required contribution toward payment of premiums; or
5. the date the Insured is no longer Actively at Work; however,

if the Insured is no longer Actively at Work as a result of a disability, layoff, or leave of absence he may continue to be eligible for group insurance coverage, except short term disability coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, provided all premiums are paid when due.
Leave of Absence	Until the end of the month following the month in which the leave of absence began, provided all premiums are paid when due; or governed by the Employer's Human Resource policy on family and medical leaves of absence, for up to 12 weeks during a leave of absence elected under the federal Family and Medical Leave Act of 1993, provided the leave of absence was approved in advance and in writing by the Employer and all premiums are paid when due.

TERMINATION OF POLICY

Termination of this Policy under any conditions will not prejudice any claim which is incurred while this Policy is in force.

If the Policyholder fails to pay any premium within the grace period, this Policy will terminate as of the last date for which premium was paid. Either We or the Policyholder may terminate this Policy by advance written notice delivered at least 31 days prior to the termination date; but this Policy will not terminate during any period for which premium has been paid. The Policyholder will be liable to Us for all premiums due and unpaid for the full period for which this Policy is in force.

We may not renew coverage if:

1. the number of Employees insured is less than ten (10); or
2. less than 100% of the Employees eligible for any noncontributory insurance are insured for it; or
3. less than 75% of the Employees eligible for any contributory insurance are insured for it; or
4. the Policyholder fails:
    a. to furnish promptly any information which We may reasonably require; or
    b. to perform any other obligations pertaining to this Policy.

Termination may take effect on an earlier date when both the Policyholder and We agree.

GENERAL PROVISIONS (TX)

ENTIRE CONTRACT

This Policy, the attached Application, and the enrollment forms of the Insureds are considered to be the entire contract.

STATEMENTS

We consider any statements made by the Policyholder or any Insured, in the absence of fraud, to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy unless it is contained in a written application signed by the Insured and a copy of such application is or has been given to him or to his beneficiary or personal representative.

POLICY AMENDMENTS

This Policy may be changed at any time by a written agreement between the Policyholder and Us. Any Policy amendment is subject to the law of the state in which it is delivered. Only Our executive officers are authorized to amend this Policy. We are not bound by any agreement or promise made by someone other than Our executive officers.

INDIVIDUAL CERTIFCATES

We will give the Policyholder a certificate to deliver to each Insured. It explains the insurance coverage provided under the Policy, to whom benefits are payable, and the rights and conditions set forth in the conversion provision. The Policyholder shall give a certificate to each Insured.

A certificate amendment will be sent to the Policyholder for delivery to each Insured if this Policy is amended.

INCONTESTABILITY

We will not contest the validity of the Policy, except for nonpayment of premium, after it has been in force for two (2) years from its effective date. We will not contest the validity of an Insured's insurance after his insurance has been in force for two (2) years during his lifetime.

MISSTATEMENT OF AGE

If an Insured has misstated his age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

POLICYHOLDER RECORDS

The Policyholder must keep records which detail each Employee's eligibility for benefits under this Policy. We may examine this information at any time.

If an eligible Employee has informed the Policyholder of his intention to enroll for group insurance and has paid any premiums, his insurance will not be made invalid solely due to a clerical error made by the Policyholder. However, if We are not notified about the termination of any Employee, We will not be required to continue insurance beyond the termination date set forth in the Policy.

CONFORMITY WITH STATE LAW

If any part of this Policy does not conform to a state statute in the state in which it is issued or delivered, it is amended to conform with the minimum requirements of the statutes of that state.

ASSIGNMENT

The life insurance benefits provided under this Policy are assignable by an Insured. In addition, the Insured may assign to anyone other than the Policyholder any incident of ownership he may possess. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

RETENTION OF DISCRETION

Fort Dearborn Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Fort Dearborn Life and such decisions shall be final and conclusive.

FORT DEARBORN LIFE INSURANCE COMPANY
(herein called We, Us, Our)

AMENDATORY RIDER (TX)

This Rider is made part of the Policy or Certificate to which it is attached. This Rider amends the Section entitled "Accidental Death, Dismemberment and Loss of Sight Benefit" and is subject to all the provisions of the Policy not in conflict with the provisions of this Rider.

The "Accidental Death, Dismemberment and Loss of Sight Benefit" Section of the Policy and Certificate is deleted in its entirety and replaced with the following:

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)

If, while insured under this Policy, an Insured suffers an Injury in an Accident, We will pay for those Losses set forth in the subsection entitled "Table of Losses" below. The amount paid will be as stated in the Table of Losses but not more than the Principal Sum set forth in the Application. The Loss must:

1. occur within 365 days of the Accident; and
2. be the direct and sole result of the Accident; and
3. be independent of all other causes.

TABLE OF LOSSES

Principal Sum for Loss of:	**One-half of the Principal Sum for Loss of:**	**One-Quarter the Principal Sum for Loss of:**
Life	Sight of One Eye	Thumb and Index Finger of Same Hand
Both Hands	One Hand	
Both Feet	One Foot	
One Hand and One Foot	Speech or Hearing	
Speech and Hearing		
Sight of Both Eyes		
One Hand and the Sight of One Eye		
One Foot and the Sight of One Eye		

With respect to hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

The total amount of AD&D benefits payable for all Losses for any Insured resulting from any one Accident will not be greater than the Principal Sum set forth in the Application.

Except as provided in a particular benefit, We will pay benefits for Loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other Losses will be paid to the Insured.

SEAT BELT BENEFIT

We will pay an additional benefit, the Seat Belt Benefit, of the lesser of the Insured's Principal Sum or $25,000 if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile, if:

1. the automobile is equipped with Seat Belts;
2. the Seat Belt was in actual use and properly fastened at the time of the Accident;
3. the position of the Seat Belt is certified in the official report of the Accident or by the investigating officer. A copy of the police Accident report must be submitted with the claim; and
4. the Insured was driving or riding in an automobile driven by a licensed driver who was neither:
   a. intoxicated or driving while impaired. Intoxication and impairment shall be determined by the law of the jurisdiction in which the Accident occurs, with or without conviction; nor
   b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

If such certification is not available and if it is unclear whether the Insured was properly wearing a Seat Belt, then We will pay an additional benefit of $1,000.

Seat Belt means those belts that form an occupant restraint system.

AIR BAG BENEFIT

We will pay an additional benefit, the Air Bag Benefit, equal to 5% of the Principal Sum of the AD&D Benefit if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile provided that:

1. the Insured was positioned in a seat that was equipped with a factory-installed Air Bag;
2. the Insured was properly strapped in the Seat Belt when the Air Bag inflated; and
3. the police report establishes that the Air Bag inflated properly upon impact.

The maximum Air Bag Benefit payable is $5,000.00. If it is unclear whether the Insured was properly wearing Seat Belt(s) or if it is unclear whether the Air Bag inflated properly, then the Air Bag Benefit will be $1,000.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

REPATRIATION BENEFIT

We will pay an additional benefit, the Repatriation Benefit, of up to $5,000 of the Principal Sum of the AD&D Benefit for the preparation and transportation of an Insured's body to a mortuary if:

1. the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life; and
2. the Insured's death occurs at least 75 miles away from the Insured's principal residence.

EDUCATION BENEFIT

We will pay an additional benefit, the Education Benefit, to the Insured Employee's Dependent Student if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured Employee's life.

Definitions which apply to the Education Benefit:

Student means a Dependent Child who, on the date of the Insured Employee's death, is:
1. A full-time post-high school student in a school of higher education; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a school of higher education within 365 days after the Insured Employee's death.

School of higher education means an institution which:
1. is legally authorized by the State in which it is located; and
2. provides either a program for:
   a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
   b. Gainful employment as long as such program is at least one year of training; and
3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

Eligible Dependent Child means any unmarried child of the Insured (whether natural, step, foster or adopted) who is:
1. at least 15 days but less than 18 years of age and dependent on the Insured for support and maintenance; and
2. not in active military service.

Eligibility will continue to age 23 for Dependent Children who are not employed full-time and are enrolled as a full-time student in a recognized school and dependent on the Insured Employee for support and maintenance. Eligibility will continue past the age limit for Dependent Children who are primarily dependent upon the Insured for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request. Note: No eligible person may be covered more than once under this Policy. If a person is covered as an Employee, he cannot be covered as a Spouse or Dependent Child of another Employee.

Amount of Benefit: The maximum Dependent Education Benefit for each dependent Student shall equal the lesser of the Insured Employee's Principal Sum or $12,000.

Payment of Benefit: We will pay the Dependent Education Benefit in four equal annual installments. We will only pay one Dependent Education Benefit to any one dependent Student during any one school year. If the dependent Student is a minor, We will pay the benefit to the legal representative of the minor.

When Benefit Ends: A dependent Student will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:
1. Our payment of the fourth installment of the Dependent Education Benefit on behalf of or to the dependent Student; or
2. At the end of the period during which Due Proof must be submitted if no Due Proof is submitted.

Special Child Education Benefit: If the Insured Employee's Eligible Dependent Child does not qualify as a Student, but is enrolled in an elementary or high school, We will pay a Child Education Benefit in the amount of $1,000. This benefit is payable once upon proof that the Insured Employee has died as a result of an accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after the Insured Employee's death, the Insured Employee's Eligible Dependent Child is a full-time student in an elementary or high school.

LIMITATIONS

We will not pay any benefit for any Loss that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any infection, except a pus-forming infection of an accidental cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted Accident; or
5. war, declared or undeclared, whether or not the Insured is a member of any armed forces; or
6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Insured's licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
9. intoxication as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

NOTICE OF CLAIM

If an Insured incurs a loss that may result in a claim for benefits under this Policy, written notice must be given to Us at Our administrative office. This must be done within 20 days after the covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice must contain enough information to identify the claimant.

CLAIM FORMS

When We receive written notice of a claim, We will send the claimant forms with which to file proof of loss. If these forms are not given to the claimant within 15 days, he will be excused from filing the forms provided he sends Us written proof of loss detailing the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS

We must receive written proof of loss within 91 days after the date of the loss for which claim was made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof of loss within 91 days will not invalidate or reduce any claim. However, except in the absence of legal capacity, proof of loss must be furnished no later than one (1) year from the date such proof is required.

For the Education Benefit, Proof of Loss must:

1. Include proof of dependent Student status; and
2. Be submitted no later than
    a. Two months after completion of course work for that particular school year if the dependent Student is enrolled in a school of higher learning at the time of the Insured's death. School year shall be deemed to begin on September 1st and end on August 31st; or
    b. Within six (6) months after enrollment in a school of higher learning if the dependent Student is in the 12th grade at the time of the Insured's death. After the first year in a school of higher learning, due proof must be submitted in accordance with paragraph (1) in this Notice of Claim Section.

PHYSICAL EXAMINATION

Upon receipt of a claim, We may examine an Insured, at Our expense, at any reasonable time, but not more frequently than once every three months.

LEGAL ACTION

No action at law or in equity may begin prior to 60 days after We receive valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

President

RATE ADDENDUM

Coverage	Initial Monthly Rate
Employee Life (per $1,000)	$.17
Accidental Death & Dismemberment (per ($1,000)	$.02

***ERISA**

To the extent these provisions conflict with any provision of the Policy, these provisions take precedence over the Policy. The Employer has established this Benefit Plan (the "Plan") as an Employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"). The Plan consists of an insurance policy(ies), including the Master Application and any Amendments (collectively, the "Policy").

ALLOCATION OF AUTHORITY

Plan Administrator

The Employer shall be the Plan Administrator and Named Fiduciary of the Plan. As such, the Employer has full discretionary and final authority and control over the Plan. This authority includes all of the power and authority contemplated by ERISA with respect to the Plan, including but not limited to the authority to:

1. Appoint or employ those parties necessary to administer the Plan;
2. Prescribe the rules and procedures under which the Plan shall operate;
3. Communicate with employees about their participation in the Plan;
4. Review and approve any financial or other reports prepared by any party appointed under paragraph (1);
5. Establish a funding policy consistent with the purposes of the Plan and ERISA; and
6. Amend, terminate or suspend the Plan in accordance with the procedure set forth herein.

The Plan Administrator appoints the Insurer to:

1. Resolve all matters when a review pursuant to the claims procedures has been requested;
2. Interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
3. Determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits under the Policy.

The Insurer shall not be a fiduciary for any other purpose. Nothing in the Plan shall affect the obligations of the Insurer with respect to the Policy. If any uncertainty shall arise between the information in the certificate or the Summary Plan Description ("SPD") and the Policy, or if any point is not covered in the certificate or SPD, the terms of the Policy will govern in all cases. Benefits will be paid under this Plan only if the Plan Administrator, or the Insurer if so delegated by the Plan Administrator, decides in its full discretion and final authority that the applicant is entitled to them.

AMENDMENT & TERMINATION

Without consent of the participants and their beneficiaries, the Employer may amend or terminate, in whole or in part, the Plan at any time. Any such amendment or termination shall be according to the Employer's authorized procedures. Any such authorization may be either specific to such Plan or persons authorized to act on behalf of the Employer or may be general as to the duties of such person. Any amendment or termination shall be in writing and attached to the Plan. Except for termination, any amendments affecting the Policy must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing, by the Employer and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

FUNDING

The Policy is a guaranteed benefit policy as defined in Sec.401(b)(2) of ERISA. The Policy is an asset of the Policyholder (or Employer Member). No assets of the Insurer are assets of or under the Plan. The Plan may be contributory or non-contributory as stated in the Policy.

CLAIMS REVIEW PROCEDURES

*Disability Insurance Plans

*(Applies to the Waiver of Premium based on disability in Life Policies).

When the Insured or the Insured's Beneficiary are eligible to receive benefits, the Insured or the Insured's Beneficiary or authorized representative (collectively, the "claimant") must notify the Plan Administrator by submitting the proper form. This may be done by sending notice of the claim to the Plan Administrator who has been appointed to assist the Insurer in the claims processing for this Plan or by contacting the Insurer directly at:

Claims Department
Fort Dearborn Life Insurance Company
2400 Lakeside Blvd.
Richardson, TX. 75082-7399
1-800-778-2281

The Insurer will give the claimant a written response to the claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurer notifies the claimant in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If the claim is extended due to the claimant's failure to submit information necessary to decide the claim, the time for decision shall be tolled from the date on which the notification of the extension is sent to the claimant until the date the Insurer receives the claimant's response to the request. This period will be no longer than 45 days after the Insurer has requested the information. At that time the Insurer will decide the claimant's claim based on the information the Insurer has at that time.

If the claim is denied, in whole or in part, the claimant will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that have to be followed to have the claim reviewed;
- a statement concerning the right to bring a civil action under section 502(a) of ERISA after the appeal is filed and a written denial on appeal is given; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to the claimant upon request; and
- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided to the claimant free of charge upon request.

If the claim has been denied, in whole or in part, it may be appealed to the Insurer for a full and fair review. The claimant has at least 180 days to appeal from the claim denial.

The claimant may:

a) request a review upon written application within 180 days of the claim denial;
b) request, free of charge, copies of all documents, records and other information relevant to the claim; and
c) submit written comments, documents, records and other information relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurer will make a decision no more than 45 days after receiving the appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurer notifies the claimant in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If the claim is extended due to the claimant's failure to submit information necessary to decide the claim on appeal, the time for the Insurer's decision shall be tolled from the date on which the notification of the extension is sent to the claimant until the date the Insurer receives the claimant's response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by the Insurer no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, the claimant will receive a written notice giving the following:

- the reason for the denial;

- the Policy provisions on which the denial is based;

- an explanation of what other information, if any, may be needed to process the claim and why it is needed;

- the steps that have to be followed to have the claim reviewed;

- a statement of your right to bring civil action on denial of your appeal.

Any denied claim may be appealed to the Insurer for a full and fair review. The claimant may:

a) request a review upon written application within 60 days of receipt of claim denial;
b) review pertinent documents; and
c) submit issues and comments in writing.

A decision will be made by the Insurer no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

FORT DEARBORN LIFE INSURANCE COMPANY

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