# Group
# Short Term Disability
# Insurance

**Designed for Employees of**

## Gilbert Chamber of Commerce

# CNA Group Life Assurance Company

Home Office: 2 North LaSalle Street, Suite 2500
Chicago, Illinois 60602

Executive Offices: 200 Hopmeadow Street
Simsbury, Connecticut 06089

A Stock Company

THE HARTFORD

**Having issued Group Policy No. 83154620**

**to**

**Group Benefits Insurance Trust, located in Washington D.C., for Employers in General Services Industries**
**(herein called the Holder)**

**and insuring Eligible Employees of**

**Gilbert Chamber of Commerce**
**(herein individually called the Participating Employer)**

**Customer No. 83173988**

## CERTIFICATE OF INSURANCE

CERTIFIES that *You* are insured provided that *You* qualify under the *ELIGIBILITY* provision, become insured and remain insured in accordance with the terms of the Policy. *Your* insurance is subject to all the definitions, limitations and conditions of the Policy. It takes effect on the effective date indicated in the *EFFECTIVE DATE* provision. This certificate, however, is not the Policy. It is merely evidence of insurance provided under the Policy. The Policy can be amended by mutual consent between the Employer and *Us*.

This certificate replaces and cancels any other certificate previously issued to *You* under the Policy.
CDI-1AA

Signed for CNA Group Life Assurance Company

Christine Hayer Repasy, *Secretary*

Thomas M. Marra, *President*

**Group Short Term Disability Certificate**

**NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.**

**SBDI-C**

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Note: All terms in *italics* are listed and defined in the Definitions section or within the certificate itself.

CDI-3AA

# *SCHEDULE OF BENEFITS*

## Effective as of: January 1, 2005

| | |
|---|---|
| **Holder:** | Group Benefits Insurance Trust for<br>Employers in General Services Industries |
| **Policy Number:** | 83154620 |
| **Policy Effective Date:** | October 1, 2002 |
| **Participating Employer:** | Gilbert Chamber of Commerce |
| **Participating Employer Customer Number:** | 83173988 |
| **Participating Employer Effective Date:** | January 1, 2005 |
| **Premium Rate Guarantee:** | We agree to guarantee the premium rate and not to modify the Participating Employer's coverage under the Policy until October 1, 2006 if:<br>1) There are no changes made to the program by the Participating Employer;<br>2) At least 4 eligible employees of the Participating Employer are insured under the Policy;<br>3) There are no changes in the Participating Employer's classes of employees, subsidiaries, or affiliated companies covered under the Policy or new acquisitions of the Participating Employer added under the Policy after the effective date of the Participating Employer's coverage under the Policy.<br>We have the right to change premium rates under the Policy on any premium due date after October 1, 2006. We will give 31 days written notice to the Participating Employer before any change in rate will become effective. |
| **Eligibility:** | All full-time employees of the Participating Employer working in the United States of America who are Actively at Work for the Participating Employer and who have completed the Waiting Period.<br><br>A full-time employee is one who regularly works a minimum of 30 hours per week for the Participating Employer. Part-time, seasonal and temporary employees of the Participating Employer are not eligible. |
| **Waiting Period:** | If *You* are in a class eligible for insurance on or before the Participating Employer Effective Date: 30 Days of continuous, active, full-time employment<br>If *You* enter a class eligible for insurance after the Participating Employer Effective Date: 30 Days of continuous, active, full-time employment |
| **Elimination Period:** | 14 Days – *Injury*<br>14 Days – *Sickness* |
| **STD Weekly Benefit:** | 60% of *Weekly Earnings* to a maximum benefit of $750 per week subject to reduction by deductible sources of income or *Disability Earnings*. |
| **Participating Employer's Contribution:** | 100% of premium |
| **Maximum Period Payable:** | 13 weeks or until benefits become payable under the long term disability plan, whichever first occurs. |

## *OTHER FEATURES*

The following other features are included:

- Work Incentive Benefit
- Recurrent Disability

**THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO *YOU* UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF *YOUR* CERTIFICATE.**
SOBC

# *ELIGIBILITY AND EFFECTIVE DATES*

### *Are You eligible for this insurance?*

All full-time employees of the Participating Employer working in the United States of America who are Actively at Work for the Participating Employer and who have completed the Waiting Period.

A full-time employee is one who regularly works a minimum of 30 hours per week for the Participating Employer. Part-time, seasonal and temporary employees of the Participating Employer are not eligible.

The waiting period is stated in the *Schedule of Benefits.*
CDI-4AA

### *When does Your insurance become effective?*

If *You* are eligible as of the Participating Employer's Effective Date, *Your* insurance shall take effect on such Date. If *You* become eligible after the Participating Employer's Effective Date, *Your* insurance shall become effective on the first of the month that falls on or next follows the date *You* become eligible.

If, because of *Injury* or *Sickness*, *You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.
CDI-5AA

### *Who pays for Your coverage?*

*Your* Participating Employer pays the entire cost of *Your* coverage.
CDI-6AA

# *SHORT TERM DISABILITY BENEFITS*

**Occupation Qualifier**

*Disability* means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

1) continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*; and
2) not *Gainfully Employed*.

CDI-10CB

**Earnings Qualifier**

*You* may be considered *Disabled* during and after the *Elimination Period* in any week in which *You* are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that *You* are unable to earn more than 80% of *Your Weekly Earnings* in any occupation for which *You* are qualified by education, training or experience.

*You* are not considered to be *Disabled* if *You* are able to earn more than 80% of *Your Weekly Earnings*. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDI-13AB

**Loss of Professional License or Certification**

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.
CDI-14AA

### *What is the Elimination Period and how is it satisfied?*

The *Elimination Period* begins on the day *You* become *Disabled*. It is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. *You* must be continuously *Disabled* through *Your Elimination Period*.

### *Can You satisfy Your Elimination Period if You are working?*

*You* can satisfy *Your Elimination Period* if *You* are working, provided *You* meet the definition of *Disability*.
CDI-15BA

### *What Disability Benefit are You eligible to receive?*

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time:

1) an STD Weekly Benefit; or
2) a Work Incentive Benefit.

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
CDI-16AA

### *What is Your STD Benefit and how is it calculated?*

*Your STD Weekly Benefit* will be based on *Your Weekly Earnings* as reported to *Us* by *Your* Participating Employer and for which premium has been paid.

An *STD Weekly Benefit* will be provided after the end of the *Elimination Period* if *You* are *Disabled* according to the Occupation Qualifier provision.

*We* will calculate *Your Gross STD Weekly Benefit* amount as follows:

1) Multiply *Your Weekly Earnings* by 60%.
2) The maximum *Gross STD Weekly Benefit* is $750.
3) Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross STD Weekly Benefit*.
4) Subtract the Deductible Sources of Income from *Your Gross STD Weekly Benefit*. The resulting figure is *Your Net STD Weekly Benefit*.

If a benefit is payable for less than one week, it will be prorated for each day of *Disability*.
CDI-17AB

### *How do We define Earnings?*

*Weekly Earnings* equals the weekly wage or salary that *You we*re receiving from *Your* Participating Employer on the *Date of Disability*. It includes:

1) employee contributions made through a salary reduction agreement with *Your* Participating Employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2) commissions averaged over the preceding 12-month period or length of employment if less; and
3) bonuses averaged over the preceding 12-month period or length of employment if less; and
4) amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1) overtime pay;
2) Your Participating Employer's contribution on Your behalf to a Retirement Plan or deferred compensation arrangement; or
3) any other extra compensation.

CDI-19AA

### *What are the Deductible Sources of Income?*

The *Gross Weekly Benefit* under this policy shall be reduced by *Disability* benefits paid, payable, or for which there is a right under:

1) Any sick leave or salary continuance plan provided by or through the Participating Employer;
2) Any Statutory Disability Benefit Law.

CDI-20AB

### *What other sources of income are not deductible?*

*We* will not reduce *Your Gross STD Weekly Benefit* by any of the following:

1) deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2) credit *Disability* insurance;
3) pension plans for partners;
4) military pension and *Disability* income plans;
5) franchise *Disability* income plans;
6) individual *Disability* income plans;
7) a *Retirement Plan* from another Employer;
8) profit sharing plans;
9) thrift or savings plans;
10) individual retirement account (IRA);
11) tax sheltered annuity (TSA);
12) stock ownership plan.

CDI-21AB

### *Can You work and still receive benefits?*

While *Disabled, You* may qualify for the Work Incentive Benefit.
CDI-22AA

**Work Incentive Benefit**

A Work Incentive Benefit will be provided if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period,* or after a period during which *You* received *STD Weekly Benefits*.

The Work Incentive Benefit will be equal to the *Net STD Weekly Benefit* amount less that amount of *Your Disability Earnings* which, when combined with *Your Net STD Weekly Benefit*, exceeds 100% of *Your Weekly Earnings* prior to *Disability*.

The Work Incentive Benefit will cease on the earliest of the following:

1) the date *You* are no longer *Disabled;* or
2) the end of the *Maximum Period Payable*.

CDI-23BB

### *How long will You receive benefits under this program?*

*We* will send *You* a payment for each week of *Disability* for the *Maximum Period Payable* as shown in the *Schedule of Benefits.* Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.
CDI-27AB

### *What happens if Your Disability recurs?*

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 14 days after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the Policy that were in effect at the time the prior *Disability* began.

*Disability* which recurs more than 14 days after the end of a prior *Disability* are subject to:

1) a new *Elimination Period*;
2) a new *Maximum Period Payable*; and
3) the other provisions of the Policy that are in effect on the date the *Disability* recurs.

*Disability* must recur while *Your* coverage is in force under the Policy.
CDI-28AA

# *EXCLUSIONS AND LIMITATIONS*

### *What are the exclusions and limitations under this program?*

The Policy does not cover any loss caused by, contributed to, or resulting from:
CDIX-1AA

- declared or undeclared war or an act of either;
CDIX-2AA

- a *Pre-existing Condition*;
CDIX-4AA

- attempted suicide, while sane or insane, or intentional self-inflicted *Injury* or *Sickness*;
CDIX-5AA

- commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred;
CDIX-6AA

- a *Mental Disorder*;
CDIX-8AA

- Substance Abuse;
CDIX-9AA

- Occupational *Injury* or *Sickness*;
CDIX-10AA

Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
CDIX-12AA

Benefits will not be payable if *Your* Participating Employer is willing to make reasonable accommodations to allow *You* to return to *Your Regular Occupation* with a loss of income no greater than 20% of *Monthly Earnings*, and *You* refuse to return to work.
CDIX-14AA

# *TERMINATION OF COVERAGE*

### *When will Your insurance terminate?*

*Your* coverage will terminate on the earliest of the following dates:

1) the date on which the Participating Employer's coverage under the Policy is terminated;
2) the date at the end of the period for which premium has been paid if the Participating Employer fails to pay the required premium for *You* within 31 days after the premium due date, except for an inadvertent error; or
3) the date *You*:
    a) are no longer a member of a class eligible for this insurance,
    b) withdraw from the program,
    c) are retired or pensioned, or
    d) cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the Participating Employer have agreed in writing in advance of the leave to continue insurance during such period. Orders to active military service for 2 months or less will be covered subject to continued payment of premium.

Termination will not affect a covered loss which began before the date of termination.
CDI-30AB

# *FILING A CLAIM*

## *What are the Claim Filing Requirements?*

### Initial Notice of Claim

*We* ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The Participating Employer can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department, P.O. Box 946730, Maitland, FL 32794-6730 or given to *Our* Agent.

### Written Proof of Loss

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the Participating Employer and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the Proof of *Disability* provision.

### Time Limit for Filing *Your* Claim

*You* must furnish *Us* with written proof of loss within 90 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is stated in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1) It was not reasonably possible to give written proof during the 1-year period; and
2) Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

### Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to do so may delay, suspend or terminate *Your* benefits.

1) The date *Your Disability* began;
2) The cause of *Your Disability*;
3) The prognosis of *Your Disability*;
4) Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5) Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6) The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7) Appropriate documentation of *Your Weekly Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8) If *You* were contributing to the premium cost, *Your* Participating Employer must supply proof of *Your* appropriate payroll deductions.
9) The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10) If applicable, proof of incurred costs covered under other benefits included in the Policy.

**Continuing Proof of *Disability***

*You* may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request. Failure to do so may delay, suspend or terminate *Your* benefits.

**Examination**

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may deny, suspend or terminate benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

**Authorization and Documentation *You* will be asked to supply**

1) *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information which support *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2) *You* will be required to supply proof that *You* have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3) *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Income Benefits. *You* must tell *Us* the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AB

## *Time of Payment of Claim*

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid on a weekly basis, so long as *You* continue to qualify for it.

*We* will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your:* 1) spouse; 2) children including legally adopted children; 3) parents; 4) brothers or sisters; or 5) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

CDI-37AB

## *Can you assign Your benefits?*

*Your* benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

CDI-38AA

## *What will happen if a claim is overpaid?*

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income; when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery.

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.

CDI-39AA

### *Fraud*

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.
CDI-42AA

## *UNIFORM PROVISIONS*

### *Entire Contract; Changes*

The Policy, the Participating Employer's application, the employee's certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract bet*we*en the parties. Coverage under the Policy can be amended by mutual consent betw*e*en the Participating Employer and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

### *Statements on the Application*

Any statement made by the Participating Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Participating Employer or *You*, whoever made the statement. No statement of the Participating Employer will be used to void the Participating Employers' coverage under the Policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

### *Legal Actions*

No legal action of any kind may be filed against *Us*:

1) within the 60 days after proof of *Disability* has been given; or
2) more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

### *Conformity with State Statutes*

If any provision of the Policy conflicts with the statutes of the state in which the Policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.
CDI-40AB

### *General Provisions*

*We* have the right to inspect all of the Participating Employer's records on the Policy at any reasonable time. This right will extend until:

1) 2 years after termination of the Participating Employer's coverage under the Policy; or
2) all claims under the Policy have been settled,

whichever is later.

The Policy is in the Holder's possession and may be inspected by *You* at any time during normal business hours at the Holder's office.

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
CDI-43AB

# *DEFINITIONS*

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized and italicized in the text. As *You* read this certificate, refer back to these definitions.

***Actively at Work*** or ***Active Work*** means that *You* must be:

1) working at the Participating Employer's usual place of business, or on assignment for the purpose of furthering the Participating Employer's business; and
2) performing the *Material and Substantial Duties* of *Your Regular Occupation* on a full-time basis.

CDID-1AB

***Appropriate and Regular Care*** means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.
CDID-4AA

***Date of Disability*** is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Occupation.*
CDID-5AA

***Disability*** or ***Disabled*** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.
CDID-6AA

***Disability Earnings*** is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive. It does not include Social Security, sick pay, salary continuance payments or any other *Disability* payment *You* receive as a result of *Your Disability*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDID-7AB

***Doctor*** means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.
CDID-8AA

***Elimination Period*** means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Schedule of Benefits*.
CDID-9AA

***Gainful Employment*** or ***Gainfully Employed*** means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, for the Participating Employer or another employer, and which *We* approve and for which *We* reserve the right to modify approval in the future.
CDID-10AA

***Generally Accepted Medical Practice*** or ***Generally Accepted in the Practice of Medicine*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
CDID-11AA

***Gross STD Weekly Benefit*** means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AGross

***Hospital or Health Care Facility*** is a legally operated, accredited facility licensed to provide full-time care and treatment for the condition(s) causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.
CDID-12AA

***Injury*** means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.
CDID-13AA

***Insured Employee*** means an employee whose insurance is in force under the terms of the Policy.
CDID-14AA

***Male pronoun***, whenever used, includes the female.
CDID-16AA

***Material and Substantial Duties*** means the necessary functions of *Your Regular Occupation* which cannot be reasonably omitted or altered.
CDID-17AA

***Maximum Medical Improvement*** is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
CDID-18AA

***Maximum Period Payable***, as shown in the *Schedule of Benefits*, means the longest period of time that *We* will make payments to *You* for any one period of *Disability*.
CDID-32AA

***Mental Disorder*** means a disorder found in the current diagnostic standards of the American Psychiatric Association.
CDID-19AA

***Net STD Weekly Benefit*** means the *Gross Short Term Disability Weekly Benefit* less the Deductible Sources of Income.
CDID-20ANet

***Pre-existing Condition*** means a condition for which medical treatment or advice was rendered, prescribed or recommended within 3 months prior to *Your* effective date of insurance. A condition shall no longer be considered pre-existing if it causes *Disability* which begins after *You* have been insured under the Policy for a period of 12 months.
CDID-21BA

***Regular Occupation*** means the occupation that *You* are performing for income or wages on *Your Date of Disability*. It is not limited to the specific position *You* held with *Your* Participating Employer.
CDID-22BA

***Retirement Plan*** means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

***Schedule of Benefits*** means the schedule which is a part of this certificate.
CDID-28AA

***STD*** means Short Term *Disability*.
CDID-34AA

***Sickness*** means sickness or disease causing *Disability* which begins while *Your* coverage is in force.
CDID-26AA

***We***, ***Our*** and ***Us*** mean the CNA Group Life Assurance Company, Chicago, Illinois.
CDID-29AA

***Weekly Benefit*** means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AA

***You***, ***Your*** and ***Yours*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
CDID-30AA

# *IMPORTANT ERISA WELFARE PLAN INFORMATION*

The following section contains information provided to You at the request of the Plan Administrator of Your Plan to meet certain requirements of the Employee Retirement Income Security Act of 1974, as amended, (ERISA). All inquiries related to the following material should be referred directly to Your Plan Administrator.

## *DISCRETIONARY AUTHORITY*

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto. The plan administrator and other plan fiduciaries have discretionary authority to determine Your eligibility for and entitlement to benefits under the Policy. The plan administrator has delegated sole discretionary authority to CNA Group Life Assurance Company to determine Your eligibility for benefits and to interpret the terms and provisions of the plan and any policy issued in connection with it.

# Hartford Life Group Insurance Company

Home Office: 2 North LaSalle Street, Suite 2500
Chicago, Illinois 60602

Executive Offices: 200 Hopmeadow Street
Simsbury, Connecticut 06089

A Stock Company

THE HARTFORD

## *ENDORSEMENT*

**CHANGE IN NAME OF UNDERWRITING COMPANY**

## Participating Employer: Gilbert Chamber of Commerce

## Customer Number: 83173988

This endorsement is made a part of, and terminates and takes effect at the same time as, the policy or certificate to which it is attached.

It amends the policy or certificate as stated below:

The name CNA Group Life Assurance Company is replaced with the name Hartford Life Group Insurance Company wherever it appears.

In all other respects, the policy and certificate to which this amendment is attached will remain the same.

Signed for Hartford Life Group Insurance Company

Christine Hayer Repasy, *Secretary*

Thomas M. Marra, *President*

Plan Arranged By:

Brown & Brown
2800 N. Central Ave. Stel 1600
Phoenix, AZ  85004


CNA Group Life Assurance Company
200 Hopmeadow Street
Simsbury, CT  06089

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