GROUP DISABILITY INCOME BENEFITS

Insurance Documents



American Fidelity Assurance Company

A member of the American Fidelity Group®

G111-227
Plan G1
(CA)

American Fidelity Assurance Company
A member of the American Fidelity Group®

Dear Valued Customer:

Thank you for giving American Fidelity Assurance Company the opportunity to help serve your insurance needs. We appreciate having you as a customer, and congratulate you on your wise decision to protect yourself and your family with this coverage.

This is your new Group Disability Income Benefit certificate. Please review the documents carefully. Feel free to call us if you have any questions or are in need of assistance.

Contact a Customer Service Representative at 1-800-323-3748 or locally at 405-523-5071. Claim questions can be directed to 1-800-662-1113, or you can visit us on the web at www.AFAdvantage.com for any of your insurance needs.

Notice for insureds living in a community property state (Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin):

If you have designated a beneficiary other than your spouse, we may be required to pay a portion of the proceeds to your spouse at the time of your death, unless your spouse has signed a spousal waiver form. To obtain a spousal waiver form, please visit our website or call a Customer Service Representative.

Sincerely,



President

2000 N. CLASSEN BOULEVARD * P.O. BOX 25523 * OKLAHOMA CITY, OKLAHOMA 73125

We are here to serve you . . .
As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If you have any questions regarding a claim, please call Benefits at 1-800-662-1113. If you have any other questions regarding your coverage, you may reach our Customer Service department by contacting us at:

American Fidelity Assurance Company
2000 North Classen Boulevard
Oklahoma City, Oklahoma 73106
Toll Free: 1-800-323-3748

If your policy or certificate was delivered by an agent or broker, you may contact your agent or broker for assistance.

If you are not satisfied . . .
Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance. The California Department of Insurance should be contacted only after you have contacted American Fidelity Assurance Company or its representative for a satisfactory solution.

To contact the Department, write or call:

Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013

Consumer Hotline: 1-800-927-HELP

(THIS FORM IS NOT A PART OF YOUR CONTRACT.)

American Fidelity Assurance Company
A member of the American Fidelity Group®

2000 N. Classen Boulevard Oklahoma City, Oklahoma 73106

CERTIFICATE OF INSURANCE

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:
(1) You are eligible for the insurance (See ELIGIBILITY on Schedule of Benefits);
(2) You are on Active Employment on the date it is to take effect; and
(3) You become insured and remain insured in accordance with all the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.

President Secretary

NON-PARTICIPATING GROUP DISABILITY INCOME INSURANCE CERTIFICATE

WARNING: Any person who knowingly, and with intent to defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

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SCHEDULE OF BENEFITS
PLAN: G1

POLICYHOLDER: BANK OF OKLAHOMA, N.A., TRUSTEE FOR THE NATIONAL SCHOOL EMPLOYEES INSURANCE TRUST

POLICY NUMBER: G111-227

CERTIFICATE EFFECTIVE DATE: Please refer to your individual application or enrollment form, if any.

ELIGIBILITY: All employees currently specified by the Employer, Association, or Collective Bargaining Agreement

DISABILITY BENEFIT: 60% of Your Monthly Compensation, not to exceed: (1) a maximum Monthly Disability Benefit of $1,500.00; (2) a maximum covered Monthly Compensation of $2,500.00; and (3) the amount for which premium is being paid. If applicable, Your Disability Benefit will be reduced by Deductible Sources of Income as outlined in Section 3.

MINIMUM DISABILITY BENEFIT: 10% of Your Monthly Disability Benefit or $100.00, whichever is greater.

MAXIMUM DISABILITY PERIOD:

Accidental Injury:

Age	Maximum Benefit Period
59 or younger	To age 65
60 through 64	5 years
65 through 68	To age 70
69 or older	1 year

Sickness:

Age	Maximum Benefit Period
59 or younger	To age 65
60 through 64	5 years
65 through 68	To age 70
69 or older	1 year

MAXIMUM MENTAL ILLNESS PERIOD: Up to 2 years not to exceed the Maximum Disability Period (includes Hospital Confinement).

ELIMINATION PERIOD:

Accidental Injury:	180 days
Sickness:	180 days

ADJUSTMENT WITH SICK LEAVE OR OTHER SALARY OR WAGE CONTINUANCE PLANS INCLUDING SUBSTITUTE DIFFERENTIAL (See Section 3) EXTENDING BEYOND THE FOLLOWING NUMBER OF CALENDAR DAYS OF DISABILITY: 180 days

SECTION 1
DEFINITIONS

ACCIDENTAL INJURY means Accidental bodily Injury(ies) sustained by You which:

(a) is (are) independent of disease or bodily infirmity or any other cause; and
(b) takes place while Your coverage is in force.

ACTIVE EMPLOYMENT means that You are:

(a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
(b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not Disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to You. It describes Your coverage under the Policy.

DISABILITY (or Disabled) for the first 24 months of Disability, means that You are unable to perform the material and substantial duties of Your Regular Occupation. After that, Disability means You are unable to perform the material and substantial duties of any Gainful Occupation for wage or profit for which You are reasonably qualified by training, education, or experience.

DISABILITY PAYMENT means Your Disability Benefit minus any Deductible Sources of Income as outlined in Section 3.

EFFECTIVE DATE means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

ELIMINATION PERIOD means that period of time, which starts after Your Effective Date of coverage, during which:

(a) You are Disabled; and
(b) no Disability Benefits are payable.

EMPLOYER means the individual, company, corporation, or governmental entity where You are on Active Employment and includes any division, subsidiary, or affiliated company named in the Policy.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide You with an income of at least the lesser of the following:

(a) Your Disability Benefit; or
(b) 60% of Your Monthly Compensation.

HOSPITAL means a licensed institution which:

(a) has on its premises:

(1) laboratory, X-ray equipment and operating rooms where major surgical operations maybe performed by licensed Physicians;
(2) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
(3) 24-hour-a-day nursing service by graduate registered nurses; and
(4) the patient's written history and medical records;

or:

(b) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall not include an institution used by You as:

(a) a place for rehabilitation;
(b) a place for rest or for the aged;
(c) a nursing or convalescent home;
(d) a long term nursing unit or geriatrics ward; or
(e) an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

INSURED means a person whose coverage has been applied for and is in force under the terms of the Policy.

MONTHLY COMPENSATION means:

(a) for contracted employees, one-twelfth (1/12) of Your contract salary through Your Employer; or
(b) for non-contracted employees, one-twelfth (1/12) of Your annual salary through Your Employer,

in effect on the date Disability began.

It excludes any additional compensation including but not limited to, overtime pay, weekend or summer work compensation, bus or other allowances, bonuses or district-funded fringe benefits.

If You become Disabled while on a covered layoff or leave of absence, We will use Your gross Monthly Compensation from Your Employer in effect just prior to the date Your absence began.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

(a) is practicing within the scope of his or her license;
(b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your sickness or Accidental Injury; and
(c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, an employee of the Employer, anyone related to You by blood or marriage, or anyone living in Your household.

POLICY means the Policy issued to the Policyholder which covers You.

POLICYHOLDER means the association, Employer, or trustee who holds the Policy.

PRE-EXISTING CONDITION means a disease, Accidental Injury, Sickness, physical condition or mental illness for which You have experienced any of the following:

(a) treatment;
(b) incurred expense;
(c) took medication;
(d) received care or services including diagnostic testing or related measures; or
(e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before Your Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accidental Injury, Sickness, physical condition or mental illness.

REGULAR AND APPROPRIATE CARE means:

(a) You personally visit a Physician as frequently as medically required, according to standard medical practice, to effectively manage and treat Your disabling condition(s); and
(b) You are receiving appropriate treatment and care for Your disabling condition(s), which conforms with standard medical practice, by a Physician whose specialty or experience is the most appropriate for such disabling condition(s), according to standard medical practice.

REGULAR OCCUPATION means the occupation You are routinely performing when Your Disability begins. We will look at Your occupation as it is normally performed in the national economy, rather than how the work tasks are performed for a specific Employer or at a specific location.

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SICKNESS means a disease or illness (including pregnancy). Disability must begin while this coverage is in force.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who:

(a) are on Active Employment as employees of the Policyholder, or members or employees of a member of the Policyholder;
(b) qualify as eligible Insureds as defined in the Policyholder's application; and
(c) meet the definition of Eligibility as stated in the Schedule,

are eligible to be insured under the Policy. Evidence of insurability acceptable to Us may be required.

EFFECTIVE DATE

Your insurance will take effect on the Effective Date of the Policy if You:

(a) apply in writing on or before said Effective Date;
(b) meet Our underwriting rules; and
(c) are on Active Employment, as defined in Section 1.

After the Effective Date of the Policy, Your insurance will take effect on the requested Effective Date or the date We approve the written application, if any (subject to Our underwriting rules), whichever is later, provided You are on Active Employment and premium has been paid.

Employees/members who want to apply for this insurance must apply for coverage that will provide benefits according to the applicable class set out in the Policyholder's application.

If You are not on Active Employment due to an Accidental Injury or Sickness when Your coverage would otherwise take effect, it will take effect after the date You go back to Active Employment for at least 5 consecutive workdays.

Any changes in the Disability Benefit, Elimination Period or Maximum Disability Period will take effect on the requested Effective Date of such changes or the date We approve the written application, if any (subject to Our underwriting rules), whichever is later, provided premium has been paid and provided You are on Active Employment.

Any change in the Policy provisions will apply only to covered periods of Disability which begin after the Effective Date of such changes, subject to all the provisions of the Policy.

SECTION 3
DISABILITY BENEFITS

Disability Payments will be provided if You furnish Proof of Loss that You are Disabled and under the Regular and Appropriate Care of a Physician. Disability must:

(a) be due to a covered Accidental Injury or Sickness; and
(b) begin while Your coverage is in force.

Disability Payments will be provided for each period You remain Disabled due to a covered Disability and under the Regular and Appropriate Care of a Physician which continues beyond the Elimination Period.

No Disability Payment will be provided for any period in which You are not under the Regular and Appropriate Care of a Physician.

Disability Payments will be provided for only one Disability when:

(a) more than one Disability exists at the same time; or
(b) a Disability results from two or more causes.

If any Disability Payment is to be paid for less than a full month, the amount of benefit will be reduced pro rata on the basis that one day's benefit equals one-thirtieth (1/30) the Disability Benefit.

Disability will be deemed to have commenced on the date You first receive personal treatment from a Physician following continuous cessation of work.

SUCCESSIVE DISABILITIES are those Disabilities which result from the same or related causes for which benefits are payable under the Policy and will be considered one period of Disability unless the Disabilities are separated by Your return to:

(a) Active Employment; or
(b) any other Gainful Occupation,

for at least 3 consecutive months. A Disability due to a different or unrelated cause will be considered a new period of Disability.

Any Disability which begins after termination of coverage:

(a) will not be considered a Successive Disability; and
(b) will not be covered under the Policy.

IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING

Your Disability Payment will be the lesser of:

(a) the Disability Benefit (as indicated on Your application for coverage, as approved by Us) less any Deductible Sources of Income You receive or are entitled to receive; or,
(b) 60% of Your Monthly Compensation less any Deductible Sources of Income You receive or are entitled to receive.

DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include:

(a) other group disability income;
(b) governmental or other retirement system as a result of Your Regular Occupation, whether due to disability, normal retirement or voluntary election of retirement benefits;
(c) United States Social Security Act or similar plan or act, including any amounts due Your dependent(s) on account of Your Disability;
(d) sick leave or other salary or wage continuance plans including substitute differential or similar pay provided by the Employer which extend beyond the period stated in the Schedule of Benefits;
(e) State Disability; and
(f) unemployment compensation.

In the case of other group disability insurance which provides for a reduction of benefits payable under this group disability income policy, Our liability under this group disability income policy shall equal its pro rata share of the Disability Payment. The pro rata share shall be determined by dividing the Disability Payment by the total of the monthly benefit payable under all group disability income policies under which You are entitled to receive benefits and multiplying that result by the Disability Payment.

If We determine that You may qualify for benefits under items (b) or (c) listed above, We may estimate the amount of benefits You may be entitled to receive.

Your Disability Payment will not be reduced by the estimated amount if You:

(a) apply for benefits under items (b) and/or (c) listed above and submit proof of application to Us; and,
(b) appeal any denial received to all administrative levels We feel are necessary; and,
(c) sign the Reimbursement Agreement form, which states You promise to repay any overpayment caused by receipt of benefits from a Deductible Source of Income for a period previously paid by Us at the time the benefits are received.

If Your Disability Payment has been reduced by an estimated amount, We will adjust the Disability Payment when proof is received:

(a) of the amount awarded; or
(b) that benefits have been denied and all appeals We feel necessary have been completed.

REIMBURSEMENT OF OVERPAYMENT

If You receive a lump sum payment from a Deductible Source of Income for a period previously paid by Us, any resulting overpayment made by Us will be due to Us on a lump sum basis.

LUMP SUM RETIREMENT WITHDRAWALS

If You have the option of taking retirement benefits on a monthly basis but choose to receive retirement benefits on a lump sum basis, We will assume You are receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS

The Disability Payment will not be reduced due to a cost of living increase if the increase takes effect after the onset of Disability and while benefits are payable under the Policy.

MINIMUM DISABILITY BENEFIT

The Disability Payment payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule of Benefits.

IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING

We will provide a Disability Payment if You are Disabled and Your monthly Disability Earnings, if any, are less than 20% of Your Monthly Compensation due to the same Sickness or Accidental Injury.

If You are Disabled and Your Disability Earnings are greater than 20% of Your Monthly Compensation due to the same Sickness or Accidental Injury, We will figure Your payment as follows:

You will receive payments based on the percentage of Monthly Compensation You are losing due to Your Disability computed as follows:

(a) subtract Your Disability Earnings from Your Monthly Compensation;
(b) divide the answer in item (a) by Your Monthly Compensation. This is Your percentage of lost earnings; and
(c) multiply Your Disability Payment by the answer in item (b).

We will stop payments and Your claim will end, if at any time You are no longer Disabled or if Your Disability Earnings exceed 80% of Your Monthly Compensation or at the end of 1 year, whichever comes first.

DISABILITY EARNINGS means the gross monthly earnings You receive while Disabled and working.

The Elimination Period cannot be satisfied with days You are Disabled and working.

TERMINATION OF BENEFITS

Disability Payments will end on the earliest of these dates:

(a) the date You are no longer Disabled;
(b) the date Your Disability Earnings are more than 80% of Your Monthly Compensation;
(c) the date You die;
(d) the last day Disability Payments are made according to the Schedule of Benefits;
(e) the date You fail to provide Us with written proof of Your Disability, satisfactory to Us;
(f) the date You cease to be under the Regular and Appropriate Care of a Physician, refuse to undergo an examination by a Physician, or refuse vocational testing when We require such examination or testing;
(g) the date You refuse to receive medical treatment that is generally acknowledged by Physicians to cure or improve Your condition so as to reduce its disabling effect;
(h) the date You refuse to try or attempt to work with the assistance of:

    (1) Modifications made to Your work environment, functional job elements or work schedule; or
    (2) Adaptive equipment or devices,

    that a Physician has indicated will allow a return to Your own occupation and which accommodations are approved by Your Employer.

MENTAL ILLNESS LIMITED BENEFIT

If You are Disabled due to a Mental Illness, regardless of the cause, Disability Payments will be provided for the period of Disability shown in the Schedule of Benefits as the Maximum Mental Illness Period if:

(a) You are under the Regular and Appropriate Care of a Physician; and
(b) You receive medical treatment (mental or medical examination alone will not be considered treatment) from either:

    (1) a registered specialist in psychiatry;
    (2) a Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary; or
    (3) a Physician, if in our opinion, a specialist in psychiatry is not required to certify that such treatment is medically necessary.

After that, benefits will be paid only if You are confined to a Hospital.

MENTAL ILLNESS means Disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as:

(a) schizophrenia;
(b) depression;
(c) manic depressive or bipolar illness;
(d) anxiety;
(e) personality disorders; and/or
(f) adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

(a) stroke;
(b) trauma;
(c) viral infection;
(d) Alzheimer's disease; or
(e) other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

SECTION 4
ADDITIONAL BENEFITS

ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT

If You are Disabled due to alcoholism or drug addiction, a limited benefit of up to 15 days for each Disability will be paid. In no event will benefits be paid for more than 15 days of Disability in any 12-month period. If drug addiction is sustained at the hands of, or while under the Regular and Appropriate Care of a Physician in the course of treatment for Accidental Injury or Sickness, it will be covered the same as any other illness.

CG111ABN-ALC

WAIVER OF PREMIUM

If You become Disabled due to a covered Accidental Injury or Sickness, and are eligible to receive a Disability Payment, Your insurance will be continued without payment of premium. Waiver of Premium will begin the first of the month following:

(a) Your satisfaction of the Elimination Period; or
(b) 6 months of continuous Disability,

whichever is later, provided premium has been paid from the beginning of Disability to the date Waiver of Premium begins.

Waiver of Premium will continue until:

(a) the end of Your Disability;
(b) the end of the Maximum Benefit Period;
(c) the date You are no longer eligible to receive a Disability Payment;
(d) the date the Policy terminates; or
(e) the date Your employment with the Policyholder or subscribing employer unit ends,

whichever first occurs. We will require proof on an annual basis that You remain Disabled during said period.

CG111ABN-WPW

PRE-EXISTING CONDITION LIMITATION

We will pay a limited Monthly Disability Benefit for a Pre-Existing Condition. This benefit will be equal to 1 month's Disability Benefit during any 12-month period. This limitation will be waived after You have:

(a) gone 12 months treatment-free for such condition after Your Effective Date of Coverage; or
(b) been continuously covered under the Policy for 24 months.

Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing period must be satisfied with respect to any increase applied for and approved by Us.

CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

For all employees who were insured by their current Employer's prior group disability carrier on the day preceding the Employer's Effective Date of coverage under this Policy and who became insured with American Fidelity Assurance Company on the Employer's Effective Date of coverage under this Policy, coverage for Pre-Existing conditions will be administered as follows:

If You were not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group disability carrier, there would be no Pre-Existing Condition Limitation applied under the American Fidelity plan. If You were not eligible for benefits under the prior group disability carrier's plan because of a Pre-Existing Condition Limitation, You would not be eligible for benefits under the American Fidelity plan until such time as You had satisfied the Pre-Existing Condition limitation prescribed in the Policy. Credit will be given for any portion of time satisfied with their current Employer's prior group disability carrier provided You replaced that coverage with American Fidelity's insurance on the Effective Date. This provision applies only up to the amount of coverage You held on the day preceding American Fidelity's Effective Date. Proof of Continuity of Coverage must be supplied by You upon request.

For those employees who were not enrolled under the current employer's prior group disability carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

SECTION 5
EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, which results from:

(a) intentionally self-inflicted injury while sane or insane;
(b) **War:** War or acts of war when serving as a member of any military, airforce, naval organization, or an auxiliary unit thereto. This exclusion includes Accidental Injury sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war or act of war. We will refund the pro rata unearned premium for any such period You or Your dependent are not covered;
(c) Accidental Injury sustained or Sickness contracted while in the service of the armed forces of any country;
(d) committing a felony;
(e) penal incarceration. We will not pay benefits for Disability or any other loss for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer; or
(f) Accidental Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which you are entitled to Workers' Compensation*.

*The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which You are entitled to Workers' Compensation benefits.

SECTION 6
TERMINATION OF INSURANCE

Your insurance coverage will end on the earliest of these dates:

(a) the date You do not meet the Eligibility requirements as defined in Section 2;
(b) the date You retire;
(c) the date You cease to be on Active Employment as defined in Section 1, except as provided for under the Leave of Absence provision in this Section;
(d) the end of the last period for which premium has been paid; or
(e) the date the Policy is discontinued.

If:

(a) Your coverage ends as a result of Your termination of Active Employment;
(b) such termination is caused by an Accidental Injury or Sickness for which Disability Benefits would be payable; and
(c) Disability is established prior to the termination of Active Employment,

then Disability Benefits will be paid as if such termination had not occurred.

Termination of the Policy will have no affect on Disability Payments which began before such termination.

We may end the coverage if You make a fraudulent claim.

We or the Policyholder may end the Policy on any premium due date. Thirty-one (31) days advance written notice of such termination must be given.

We may end the coverage of a subscribing employer unit if fewer persons are insured than required by the Policyholder's application.

LEAVE OF ABSENCE

Your coverage may be continued for up to 1 year during a Leave of Absence approved in writing by Your Employer.

SECTION 7
PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

(a) Our Home Office; or
(b) An authorized agent of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases Our liability, premium rates may be changed on the date the liability is increased.

PREMIUM REFUND

In the event of death of any person covered under the Policy, a Premium Refund may be due. Such refund will be made if death occurs prior to the end of the period for which premium has been paid. The Premium Refund will be figured on a daily pro rata basis and will be provided within 90 days from the date valid Proof of Death is received.

PROOF OF DEATH means an original, notarized death certificate.

SECTION 8
GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

(a) the Policy;
(b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
(c) Your application, if any, attached to the Certificate; and
(d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

(a) the statement is in writing; and
(b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of Ours. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

(a) avoid the coverage; or
(b) deny a claim for loss incurred or Disability (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

(a) on any future premium due date; or
(b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

NOTICE AND PROOF OF LOSS: Written Notice of Claim must be given to Us at 2000 N. Classen Boulevard, Oklahoma City, Oklahoma, 73106, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay. Proof of Loss must be given to Us within 90 days after the loss. Proof of Loss, provided at Your expense, must show:

(a) that You are under the Regular and Appropriate Care of a Physician;
(b) the date Your Disability began;
(c) the cause of Your Disability;
(d) the appropriate documentation of Your Monthly Compensation;
(e) the extent of Your Disability, including restrictions and limitations preventing You from performing Your Regular Occupation; and
(f) the name and address of any Hospital or institution where You received treatment, including all attending Physicians.

Late proof may be accepted if:

(a) it was not reasonably possible to give proof in that time; and
(b) the proof is given within one year from the date of loss. This one-year limit will not apply in the absence of legal capacity.

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of notice of claim. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

(a) in writing;
(b) containing the required information as indicated in the Proof of Loss Provision; and
(c) within the time stated in the Notice and Proof of Loss Provision.

TIME OF PAYMENT OF CLAIMS: All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written proof. Benefits for any other covered loss will be paid as soon as We receive written proof of such Proof of Loss. If the claim is not paid or denied within forty-five (45) days of receipt of proper Proof of Loss, interest on overdue claims shall bear simple interest at the rate of ten percent (10%) per year.

PAYMENT OF BENEFITS: All benefits will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate. If a benefit is to be paid to Your estate, or to You and You are not competent to give a valid release, We may pay up to $1,000 of such benefit to one of Your relatives who is deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, We have the right to have You:

(a) examined as often as is reasonably necessary. We will pay for such examination; and/or
(b) interviewed by an authorized Company representative to determine the extent of any Sickness or Accidental Injury for which You have made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

(a) within 60 days after written Proof of Loss has been furnished as required; or
(b) more than 3 years from the time written Proof of Loss is required to be furnished.

CERTIFICATES: An individual Certificate will be issued for delivery to You. The Certificate will describe:

(a) the benefits under the Policy;
(b) to whom benefits will be paid; and
(c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to You, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding You are not accurate:

(a) a fair adjustment of premium will be made; and
(b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CLAIM OVERPAYMENT: We have the right to recover any overpayment(s) due to:

(a) fraud;
(b) any error We make while processing Your claim; and
(c) Your receipt of Deductible Sources of Income.

With respect to (b) and (c), We cannot request a refund of an overpayment made to You more than 24 months after such payment is made unless You have agreed in writing to reimburse such overpayment. Your reimbursement to Us must be made in full. However, We will work with You to develop a reasonable method of repayment if You are financially unable to repay such overpayment. We will not recover more money than the amount overpaid to You.

American Fidelity Assurance Company
A member of the American Fidelity Group®

2000 N. Classen Boulevard Oklahoma City, Oklahoma 73106

Effective Date: _____
(If Different from the Policy or Certificate)

This Rider is applicable to California residents only.

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

Disability for the first 24 months that disability benefits are paid means that the Insured is unable to perform with reasonable continuity the material and substantial duties of his or her occupation in the usual and customary way. After that, Disability means the Insured is unable to perform with reasonable continuity the material and substantial duties of any occupation that the Insured reasonably could be expected to perform satisfactorily in light of the Insured's:

(a) age;
(b) education;
(c) training;
(d) experience;
(e) station in life; and
(f) Physical and mental capacity.

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.

Secretary

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300.000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guarantee annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P. O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

(THIS FORM IS NOT A PART OF YOUR CONTRACT)

NOTICE OF THE RIGHT TO APPEAL

You, Your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request to American Fidelity Assurance Company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Your request for review must be filed within 90 days after receipt of the written notice of denial of a claim. A decision will be rendered by American Fidelity Assurance Company, within 90 days after receipt of your request for review. If special circumstances exist or additional information is needed, the decision shall be rendered as soon as possible, but no later than 90 days after receipt of the additional information necessary to evaluate your appeal. The decision, after the review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent plan provisions on which the decision was based.