Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, South Carolina 29223-5666

Policyholder:	Barton Staffing Solutions, Inc.
Address:	1000 Corporate Blvd Suite A Aurora, Illinois, 60505

Group Policy Number:	TSE3711	Effective Date:	January 1, 2019
Issue Date:	January 1, 2019	Policy Anniversary Date:	January 1st

This is to certify that Companion Life has issued and delivered the Group Insurance Policy to the Policyholder shown above and subject to the terms of that policy you, the Insured, are eligible.

This Certificate of Insurance is evidence of your insurance under the policy and of the policy's benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions and exceptions in the policy. The policy is on file with the Policyholder and may be examined at any time during normal business hours. This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Policyholder by Companion Life to give to you under the Policy.

Signed for Companion Life Insurance Company.

J. Philip Gardham
President

GROUP CERTIFICATE PROVIDING
CRITICAL ILLNESS BENEFITS
NON-PARTICIPATING

This is a Limited Benefit Health Coverage Certificate. Certificates of this category are designed to provide limited or supplemental coverage, paying benefits ONLY upon the Occurrence and Diagnosis of a covered condition. This certificate does not provide benefits for any other disease, sickness or incapacity. This certificate does not provide for basic hospital, basic medical-surgical, or major medical expenses. Benefits provided are a supplement, and not a substitute for, medical coverage or disability insurance.

PLEASE READ THIS CERTIFICATE CAREFULLY. THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS CERTIFICATE IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS CERTIFICATE CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS CERTIFICATE CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

For service or questions about this certificate, please address any inquiries to SISCO Benefits, PO Box 389, Dubuque, IA 52004 or call 1-800-457-4726.

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SECTION 1

Schedule of Benefits

Classes of Employees Eligible for Insurance: All Active Full-Time Employees

Insured:

Employee Critical Illness Benefit Amount: $10,000

Reduction Formula: If a Covered Person is Age 60 on the Policy Effective Date, or when the Covered Person reaches Age 60, the Benefit Amount will be reduced by 25%. If a Covered Person is age 65 or more on the Policy Effective Date, or when the Covered Person reaches Age 65, the Benefit Amount will be reduced by an additional 25% (collectively a "Benefit Reduction Due to Age").

Spouse (if applicable): 50% of Insured's Benefit Amount (to a maximum of $30,000)

Children: 50% of Insured's Benefit Amount

Covered Critical Illnesses:	Benefit Amount:
• Heart Attack	100%
• Stroke	100%
• Coronary Bypass Surgery	25%
• Cancer	
• Invasive Cancer	100%
• Cancer in Situ	25%
• Major Organ Transplant	100%
• End-Stage Renal Failure	100%
• Blindness	100%
• Deafness	100%
• Paralysis	100%
• Accidental Loss of Speech	100%
• Coma	100%

The Critical Illness Benefit will be paid only if a covered condition first occurs and is diagnosed after the effective date of coverage.

SECTION 2
DEFINITIONS

2.01 "Accident" means sudden, unexpected and unintended injury which is independent of any Sickness and which takes place while the Covered Person's coverage is in force.

2.02 "Active Service" means that you are:

a) doing in the usual manner all of the regular duties of your employment 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 are said to be on Active Service on a day which is not a scheduled work day only if you would be able to perform in the usual manner all of the regular duties of your employment if it were a scheduled work day and you were actively at work on the last preceding regular work day.

2.03 "Age" means the attained age as of the last birthday.

2.04 "Benefit Payment" means the percentage of the current benefit amount applicable for that condition if the claim is payable.

2.05 "Calendar year" means the period from January 1 through December 31 of the same year.

2.06 "Certificate" means the individual certificate issued to you. It describes the coverage under the Policy.

2.07 "Company" means Companion Life Insurance Company, located in Columbia, South Carolina.

2.08 "Clinical Diagnosis" means a Diagnosis of Invasive Cancer or Cancer In Situ based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Cancer only if the following conditions are met:

a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
b) there is medical evidence to support the Diagnosis; and
c) a Physician is treating You for Invasive Cancer and/or Cancer In Situ.

2.09"Covered Person(s)" means you and Your Dependents insured under the Policy.

SECTION 2
DEFINITIONS

2.10 "Critical Illness" means the First Ever Occurrence, while the Policy is in force, of one of the following covered conditions, as defined below:

[a) Accidental Loss of Speech
b) Advanced Alzheimer's Disease
c) Angioplasty
d) Blindness
e) Cancer
   (i) Cancer In Situ
   (ii) Invasive Cancer
f) Coma
g) Coronary Bypass Surgery
h) Deafness
i) End-Stage Renal Failure
j) Heart Attack
k) Major Organ Failure
l) Motor Neuron Disease
m) Occupational HIV
n) Paralysis
o) Severe Burns
p) Stroke]

[a) "Accidental Loss of Speech" means the Diagnosis, by a Physician board-certified as medically appropriate for this condition, of the total, permanent and irreversible loss of your ability to speak as a result of an accidental injury.]

[b) "Advanced Alzheimer's Disease" means the Diagnosis, by a Physician board-certified as a Neurologist, of Advanced Alzheimer's Disease. The Covered Person must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the Covered Person requires Substantial Assistance in performing at least three of the six Activities of Daily Living (as defined below). No other dementing brain disorders or psychiatric illnesses shall meet the definition of Alzheimer's Disease, nor will they be considered a covered condition.

1. Activities of Daily Living (ADLs) refer to certain basic daily tasks necessary to maintain a person's health and safety. In the Policy, ADLs refer to the activities described below:

i. Transfer and mobility -The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.

ii.	Continence	-The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
iii.	Dressing	-Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
iv.	Toileting	-Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
v.	Eating	-Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
vi.	Bathing	-Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.

2. Substantial Assistance means hands-on assistance and stand-by assistance. For the purposes of the Policy "stand-by assistance" will be used to determine that substantial assistance by another person is required by the Covered Person to perform the ADL.

i. "Hands-on Assistance" means the physical assistance of another person without which a Covered Person would be unable to perform the ADL.
ii. "Stand-by Assistance" means the presence of another person within arm's reach, to prevent, by physical intervention, injury to the Covered Person while performing an ADL (such as being ready to catch you if you fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from your throat if you choke while eating).]

[c) "Angioplasty" means the actual undergoing of a percutaneous transluminal angioplasty deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. A Physician board-certified as a Cardiologist must perform the procedure. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.]

[d) "Blindness" means the Diagnosis, by a Physician board-certified as an Ophthalmologist, of the permanent and uncorrectable loss of sight in each of your eyes. Corrected visual acuity must either be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes.]

SECTION 2
DEFINITIONS

[e) Cancer

(i) "Cancer In Situ" means a Diagnosis of a malignant neoplasm wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer In Situ includes:

1. early prostate cancer diagnosed as T1N0M0 or equivalent staging; and
2. melanoma not invading the dermis.

Cancer In Situ does NOT include:

1. other skin malignancies;
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. benign tumors or polyps.

(ii) "Invasive Cancer" – A Diagnosis of a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Leukemias and lymphomas are included. The following are not considered Invasive Cancer:

1. pre-malignant lesions (such as intraepitherlial neoplasia); or
2. benign tumors or polyps; or
3. early prostate cancer diagnosed as T1N0M0 or equivalent staging; or
4. cancer in Situ; or
5. any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer and Cancer In Situ must be diagnosed pursuant to a Pathological or Clinical Diagnosis as explained in the Definition section.]

[f) "Coma" means the diagnosis, by a Physician board-certified as a Neurologist, that a Covered Person is in a state of unconsciousness from which they cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least 96 hours.]

[g) "Coronary Bypass Surgery" means the actual undergoing of coronary artery bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. The procedure must be performed by a Physician board-certified as a Cardiologist. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.]

[h) "Deafness" means the Diagnosis, by a Physician board-certified as an Otolaryngologist, of the permanent loss of hearing in both ears with an auditory threshold of more than 90 decibels in each ear.]

SECTION 2
DEFINITIONS

[i) "End-Stage Renal Failure" means the chronic and irreversible failure of both kidneys which requires a Covered Person to undergo periodic and ongoing dialysis. The Diagnosis must be made by a Physician board-certified in Nephrology.]

[j) "Heart Attack" means an Acute Myocardial Infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Physician board-certified as a Cardiologist and based on both:

1) new clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
2) serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Established (old) Myocardial Infarction is excluded.]

[k) "Major Organ Failure" means the clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue to be replaced with an organ(s) or tissue from a suitable human donor (excluding you) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, kidney, lung, entire heart, small intestine, pancreas, pancreas-kidney, or Allogeneic Bone Marrow. In order for the Major Organ Failure to be covered under the Policy, the Covered Person must be registered by the United Network of Organ Sharing (UNOS).

"Allogeneic Bone Marrow" transplant means the clinical evidence of bone marrow destruction or disease which requires the bone marrow of the Covered Person to be replaced with bone marrow from a suitable human donor (excluding the Covered Person) under generally accepted medical procedures. In order for the Bone Marrow transplant to be covered under the Policy, the Covered Person must be registered by the National Marrow Donor Program (NMDP).]

[l) "Motor Neuron Disease" means the unequivocal diagnosis, by a Physician board-certified as a Neurologist, of one of the following motor neuron diseases: amyotrophic lateral sclerosis (A.L.S. or Lou Gehrig's Disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy. Coverage is limited to these conditions and all other variations of motor neuron disease are excluded.]

[m) "Occupational HIV" means an infection with the Human Immunodeficiency Virus (HIV) resulting from an accidental injury which occurred in the United States after the issue date of the Policy, and which exposed the Covered Person to HIV-contaminated blood or bodily fluids during the course of the duties of their normal occupation.

Payment under this condition requires satisfaction of ALL of the following:

1. the accidental injury must be reported to the Company within 14 days of the accidental injury.
2. An HIV test must be taken within 14 days of the accidental injury and the result must be negative.
3. An HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive.
4. The accidental injury must have been reported, investigated and documented in accordance with workplace legislation and regulations.

The following are excluded:

- HIV infection acquired via sexual transmission
- HIV infection acquired via IV drug use
- HIV infection determined not to be the result of an accident.]

[n) "Paralysis" means the complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days, confirmed by a Physician board-certified as a Neurologist.]

[o) "Severe Burns" means the Diagnosis, by a Physician board-certified as a Plastic Surgeon, that a Covered Person has sustained third degree burns covering at least 20% of the surface area of their body.]

[p) "Stroke" means any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Cerebral symptoms due to migraine, cerebral injury due to trauma or hypoxia, vascular disease affecting the eye or optic nerve, ischemic disorders of the vestibular system, and transient ischemic attack (mini-stroke) are excluded. The Diagnosis must be made by a Physician board-certified as a Neurologist.]

2.11 "Date of Diagnosis" means the date the Diagnosis is established by a Physician, who is a board certified specialist where required under the Policy, through the use of clinical and/or laboratory findings as supported by a Covered Person's medical records. For a procedure, it is the date the Covered Person undergoes the procedure.

2.12 "Dependent" means Your:

(a) married spouse or party to a civil union who lives with You under age 70; or

(b) the Dependent child or children of the Insured or of the Insured's spouse from the moment of birth to age 26; and

(c) a Dependent child of the Insured or of the Insured's spouse who has attained age 26, is chiefly supported by his or her parent or dependent on other care providers, and is incapable of self-sustaining employment by reason of a handicapped condition that occurred before the attainment of the limiting age. Proof of the child's condition and dependence will be requested by Us within 2 months prior

to the date the child will cease to qualify as a child as defined above. Such proof must be submitted to Us within 31 days from the date of the request. We may require proof of the continuation of such condition and dependence but not more than once in any 12 month period. If proof is not submitted within the 31 days following any such request, coverage for the Dependent will terminate. "Dependent on other care providers" means such child requires a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services, the Department of Public Health, or the Department of Public Aid.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who is in the custody of the Insured pursuant to an interim court order of adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree.

We will not terminate coverage or deny the election of coverage for a Dependent by reason of the Dependent's age before the Dependent's 30th birthday if the Dependent (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than dishonorable discharge.

A spouse or child covered under the Policy as an Insured will not be eligible as a Dependent. If a spouse or party to a civil union who lives with the Insured are both covered as insureds, a child will be the Dependent of only one parent.

2.13 "Diagnosis" means the definitive establishment of the Critical Illness through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required under the Policy.

2.14 "Effective Date" means the date coverage takes effect under the Policy. The Effective Date of Your coverage will be the first day [after the Normal Pay Date for which the first payroll deduction is taken for this coverage] [of the month following the first payroll deduction]. The "Effective Date" will start at 12:01 a.m. at the main place of business of the Policyholder.

2.15 "Enrollment Form" means the written form(s) provided by Us that the employee uses to apply for the Policy, including any amendments and supplemental application(s) thereto, and any application(s) for a Policy change or reinstatement.

2.16 "First Occur(s)/First Occurrence/First-Ever Diagnosis or Procedure" means this Occurrence, Diagnosis or Procedure is the first time ever in a Covered Person's lifetime that he or she have experienced such covered condition, been diagnosed with that specific condition included as a covered condition, or undergone that specific Procedure included as a covered condition.

SECTION 2
DEFINITIONS

2.17 "Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

2.18 "Initial Benefit Amount" means the amount of Critical Illness Insurance coverage requested by you, which the Company subsequently approves for you.

2.19 "Insured" means any person who is eligible for insurance under Section 2 and is insured under the Policy by virtue of employment by a Policyholder.

2.20 "Maximum Benefit Amount" means the eligible total of Benefit Payments for all covered conditions as stated in the Policy, including all components of the Multiple Payment Benefit provision.

2.21 "Normal Pay Date" means the day of the week that Your employer normally issues payroll. This date will remain the same regardless of a change in the payday which may occur due to holidays.

2.22 "Occur(s)/Occurrence(s)" means an event or incident that: (1) occurs after the date coverage becomes effective under the Policy; (2) occurs while the Policy is in force; and (3) is not precluded by any specific description or exclusion stated in the Policy.

2.23 "Pathological Diagnosis" means Diagnosis of Invasive Cancer or Cancer In Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

2.24 "Physician" means a person other than You or a Covered Person; a family member of Yours; a member of the same household; or a business partner or associate of Yours; who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat sickness and injuries. The Physician must be providing services within the scope of his or her license issued by the jurisdiction in which such person's services are rendered. Such jurisdiction must be within the United States of America. The Physician must be a board certified specialist where required under the Policy.

2.25 "Policy" means the written statement of this contract effecting Critical Illness Insurance, including all clauses, riders, endorsements, applications, or other attached papers. This insurance Policy is a binding contract, issued by the Company to the Employer, which promises to pay a Benefit Amount to Covered Persons according to certain defined terms and conditions.

2.26 "Policy Effective Date" means the date that the Policy takes effect. The Policy Effective Date is shown in the Policy Schedule.

2.27 "Policyholder" means an employer who has elected in writing to participate in the coverage under the Policy.

SECTION 2
DEFINITIONS

2.28 "Proof" means written evidence satisfactory to the Company that a claimant has satisfied the conditions and requirements for a benefit described in the Policy. Proof must include all of the information required under the terms of the Policy and be timely submitted as described in the Policy. When a claim is made for a benefit described in the Policy, Proof must establish:

a) the nature and extent of the covered condition;
b) the Company's obligation to pay the claim; and
c) the claimant's right to receive payment.

Except as provided in the "Physical Examinations, Autopsy" claim provision of the Policy, Proof must be provided at the claimant's expense.

2.29 "Schedule of Benefits (or Schedule)" means the benefit schedule set forth in the Policy or Certificate.

2.30 "Treatment Free" means a period of time without the consultation, care or services provided by a physician or other health care professionals with regard to any Cancer care, including diagnostic measures and taking prescription drugs and medicines, chemotherapy and/or radiation therapy. For the purpose of this definition, "treatment" does not include maintenance drug therapy or routine follow-up visits to verify that Cancer or Cancer In Situ has not returned.

2.31 "We", "Us" and "Our" means Companion Life Insurance Company, located in Columbia, South Carolina.

2.32 "You" and "Yours" means the Insured.

SECTION 3
ELIGIBILITY AND EFFECTIVE DATE

3.01 All persons who:

(a) are on Active Service as employees of a Policyholder; and
(b) qualify as eligible Insureds as defined in the master application; and
(c) meet the definition of eligible employee as stated in the Schedule,

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

3.02 The insurance on eligible employees will take effect on the Effective Date of the Policyholder if:

(a) an application is completed on or before said Effective Date;
(b) the underwriting rules of the Company are met;
(c) such person is on Active Service; and
(d) the first premium is paid and received by the Company.

After the Effective Date of the Policyholder, the insurance of eligible employees will take effect on the first day after the Normal Pay Date for which the first payroll deduction is taken for this coverage, subject to (a), (b), (c) and (d) above and the rules stated in the master application.

3.03 If and where Dependent coverage is available under the Policy, each Dependent will be eligible for such coverage on the latest of the following dates:

(a) the day you become eligible for insurance; or
(b) the day you acquire your first Dependent.

With respect to Critical Illness coverages, if both husband and wife are eligible for coverage under the Policy and have no Dependent children, the husband and wife may only elect individual coverage. If both husband and wife are eligible for coverage under the Policy and they have Dependent child(ren), either spouse, but not both, may elect Dependent coverage.

3.04 Dependent coverage may be elected by:

(a) Completing and signing an application within 31 days of the date the Dependent becomes eligible; and
(b) By completing any required form of payroll deduction.

SECTION 3
ELIGIBILITY AND EFFECTIVE DATE

3.05 The Effective Date of coverage for each eligible Dependent will be the first day after the Normal Pay Date for which the first payroll deduction is taken for this coverage, following:

(a) the Company's acceptance of the application; and
(b) receipt of the first premium by the Company.

However, if on such date the coverage for the eligible employee has not yet taken effect, the Effective Date for Dependent coverage will be the same as the Effective Date for such employee.

If it is the first child or if dependent coverage was elected, a newborn child will become insured under the Policy automatically from the moment of birth as long as Your coverage was in force on that date. The newborn child's coverage will not continue past the 31-day period following birth unless:

(a) the Company is notified by the end of that 31-day period of the addition of such newborn child; and
(b) any applicable additional premium is paid.

An adopted child who has not attained 18 years of age, will become insured under the Policy automatically as of the date of adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of the child's adoption. Coverage for an adopted child will not continue past the 31-day period following birth unless:

(a) the Company is notified by the end of the 31-day period of the addition of such adopted child; and
(b) any applicable additional premium is paid.

In all other instances if a Dependent is totally disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of the Dependent will be deferred until the first of the month following the Dependent's cessation of total disability.

3.06 If You are not actively at work when Your coverage would otherwise take effect, coverage will take effect on the earlier of the following dates:

(a) with respect to coverage for conditions other than the disabling condition:
    (1) the day following the expiration of any continuation of coverage provided under the plan this plan replaces; or
    (2) the day coverage would otherwise take effect if the plan this plan replaces does not provide for continuation of coverage.

SECTION 4
BENEFITS

CRITICAL ILLNESS INSURANCE BENEFIT

4.01 The Company will, subject to the terms and conditions of the Policy, pay the Benefit Amount of the Policy shown in the Policy Schedule upon the Diagnosis by a Physician that a Covered Person has a covered condition under the Policy, if such covered condition First Occurred while the Policy was in force.

4.02 The covered conditions listed in the Policy Schedule are the only conditions, diseases or surgeries for which a Covered Person may receive benefits under the Policy. If a covered condition First Occurs while a Covered Person is insured under the Policy, and We receive the required Proof of the covered condition, the current benefit amount will be paid, depending on the type of covered condition.

4.03 The Benefit Payment(s) will be paid in a lump-sum to you. Benefits will not exceed the Maximum Benefit Amount. The Policy will terminate upon payment of the Maximum Benefit Amount.

MULTIPLE PAYMENT BENEFIT

4.04 The Maximum Benefit Amount payable under the policy is [3, 5] times the policy face amount.

More than one covered Critical Illness may be payable. In the case of two different covered Critical Illnesses, the latest occurrence must be separated by at least 6 months (or for Cancer at least 6 months Treatment Free) from any prior occurrence for which a benefit has already been paid in order for the new occurrence to be eligible for payment. In the case of a recurrence of a Critical Illness for which a benefit has already been paid, the two occurrences must be separated by at least 12 months or for Cancer at least 12 months Treatment Free.

A maximum of [one, two] reoccurrence[s] of any Critical Illness will be payable.

SECTION 5
EXCEPTIONS AND LIMITATIONS

5.01 Unless a Covered Person's covered condition First Occurs or is diagnosed during the coverage period of the Policy, no Benefit Amount will be payable.

If more than one covered condition is diagnosed at the same time, the Benefit Payment shall be based on the larger Benefit Amount of those diagnosed. If Benefit Amounts are the same, only one benefit will be payable as described in Section 4, Benefits, Multiple Payment Benefit.

5.02 The Company will NOT pay the Benefit Amount for a covered condition if such covered condition is caused by, results from, or occurs during:

a) intentionally causing self-inflicted injuries;

b) suicide, or any attempt at suicide, while sane or insane;

c) serving in the armed forces or any auxiliary unit of the armed forces;

d) participation in the commission or attempted commission of a felony;

e) participation in a riot or insurrection;

f) alcoholism or drug addiction; or

g) being intoxicated or under the influence of alcohol, drugs, or any narcotic (including overdose) unless administered on the advice of a physician and taken according to the physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss, or loss occurred.

SECTION 5
EXCEPTIONS AND LIMITATIONS

5.03 The Company will NOT pay the Benefit Amount for a covered condition if:

a) Such covered condition is not covered under the Policy;

b) Such covered condition First Occurred while the Policy was not in force;

c) Such covered condition was diagnosed by a person who is not a Physician;

d) Such covered condition was diagnosed outside the U.S., unless the Diagnosis is confirmed in the U.S.;

e) Such covered condition or surgical procedure was performed outside the U.S., unless on a U.S. military base or facility; or within another U.S. military or government building or facility; or

f) a Covered Person's date of birth, Age or sex was misstated on the Application and at the correct date of birth, Age or sex the Policy would not have become effective or would have terminated.

5.04 Any Benefit Amount payment under the Policy is subject to the adjustments provided in the Policy provisions; including, but not limited to, the Time Limit for Certain Defenses, Misstatement of Age or Sex, and Grace Period provisions.

5.05 When a Covered Person reaches Age [60], or are [60] or older on the Policy Effective Date, the Initial Benefit Amount will be reduced by 25%. After this reduction occurs, the current benefit amount for a category is 75% of the benefit remaining in that category on the day prior to the reduction. When a Covered Person reaches Age [65], or are [65] or older on the Policy Effective Date, the Initial Benefit Amount will be reduced by an additional 25%. After this reduction occurs, the current benefit amount for a category is 50% of the benefit remaining in that category on the day prior to the reduction.

SECTION 6
TERMINATION OF INSURANCE

6.01 The insurance on You will cease on the earliest of:

(a) the last day of the payroll deduction period during which you cease to be a member of a class eligible for coverage as shown in the Schedule;

(b) the end of the last period for which premium payment has been made to the Company;

(c) the date the Policy terminates;

(d) the last day of the payroll deduction period during which you are retired or pensioned;

[(e) with respect to you working for employers with less than 20 employees on a typical work day in the preceding Calendar Year, the last day of the payroll deduction period during which you attain age 70;]

(f) the last day of the payroll deduction period during which you terminate employment; or

(g) the date on which the maximum benefit has been paid.

6.02 The insurance on a Dependent will cease on the earliest of:

(a) the date Your coverage terminates;

(b) the end of the last period for which premium payment has been made to the Company;

(c) the date the Dependent no longer meets the definition of Dependent, as defined in the Policy;

(d) the date the Policy is modified so as to exclude Dependent coverage; or

(e) the date on which the maximum benefit has been paid.

6.03 The Company shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

6.04 The Policy, and the coverage of a Policyholder under the Policy, may be terminated as described below.

A Policyholder may terminate coverage under the Policy by giving written notice to the Company. Termination will be effective on the latter of:

(a) the date we receive the notice; or

(b) the requested termination date.

After the first anniversary date of the Policy, the Company may terminate any or all of the insurance under the Policy, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to the termination date.

SECTION 7
PORTABILITY PROVISIONS

7.01 Continuation of Insurance Benefit – You may continue you and Your Dependent's coverage if Your employment terminates. To be eligible to continue insurance, You must meet both of the following requirements on the date employment terminates:

1. You are not totally disabled.
2. You are not retired.

The Dependent's insurance may not be continued if Your insurance is not continued.

7.02 Application and Premium Payment – You must apply in writing to the Company or its administrator within 31 days after the date employment ends.

You must pay the required Premium directly to the Company or its administrator. The Premium rate will be the same rate applicable to the employer. Any rate changes which become effective for the employer will become effective for You on the same date. The first Premium payment must be made no later than 31 days after the date the insurance would otherwise terminate.

7.03 Amount of Insurance – The amount of insurance that may be continued by You and Your Dependents is the amount in effect on the date employment terminates, subject to any Benefit Reduction Due to Age.

SECTION 8
CLAIM PROVISIONS

8.01 Notice of Claim: Written notice of claim must be given within 60 days after the covered condition is First Diagnosed or as soon as reasonably possible, but in no case later than one year after the covered condition is First Diagnosed. The notice must be given to the Company at Our Home Office.

The Notice of Claim should include Your name, the Policy number, name of Covered Person, if applicable, the covered condition, if any, and an address to which the claim form should be sent. Subject to Section 9.02, no claim for loss incurred that starts two years from the date coverage begins will be reduced or denied unless excluded by name or specific description before the date of loss.

8.02 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) setting forth the nature and extent of the loss; and
(c) within the time stated in the Proof of Loss provision.

(If You reside in Georgia, the reference to 15 days is changed to 10 working days.)

8.03 Proof of Claim: Written Proof of claim, satisfactory to the Company, must be given to us within 90 days after the Occurrence of any covered condition under the Policy. Such Proof of claim must include the Physician's Diagnosis. The Company may also request additional documentation that may include documentation supported by clinical, radiological, histological and/or laboratory evidence. If it was not reasonably possible to give written Proof in the time required, we will not reduce or deny the claim for this reason if the Proof is filed as soon as reasonably possible. Unless the owner was legally incapable, this Proof must be given within one year from the date the covered condition Occurred.

8.04 Time of Payment of Claim: After the Company receives written due Proof of Claim, and subject to the terms and conditions of the Policy, we will pay within 30 days the current benefit amount then due under the Policy. Failure to pay within such period will entitle the Insured to interest at the rate of 9% per annum from the 30th day.

8.05 Payment of Claim: The Benefit Payment will be paid in a lump-sum to you. Any Benefit Payment unpaid at your death will be paid to Your Beneficiary.

8.06 Physical Examinations and Autopsy: The Company has the right to have a Covered Person examined by a Physician of its choice as often as reasonably necessary while a claim is pending. The Company will pay for such examination. In case of death, the Company may request an autopsy where it is not forbidden by law.

SECTION 9
GENERAL PROVISIONS

9.01 Entire Contract – Changes: The entire contract shall include:

(a) the Policy;
(b) the application of the Policyholder;
(c) Your enrollment form, 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. (The words "if fraud was not intended" do not apply in Georgia or North Carolina.) 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 or Your beneficiary.

The terms of the Policy can be changed only by endorsement or amendment signed by the President or Secretary of the Company. No agent may change the Policy or waive its provisions.

9.02 Time Limit on Certain Defenses: The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. After coverage for a Covered Person has been in force for two years, the Company cannot:

(a) void the coverage; or
(b) deny a claim for loss that starts after the two-year period, because of statements in the application unless they were fraudulent misstatements.

Nothing herein should be construed to prevent the Company from denying any claim on the basis that an individual was not eligible for coverage.

9.03 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 must still pay all unpaid premium due for the grace period.

The Policyholder may, by writing to the Company, 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 cancelled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder will be liable for any unpaid premium including the pro rata premium for that part of the grace period coverage was in force.

SECTION 9
GENERAL PROVISIONS

9.04 Legal Actions: 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 three years (five years in Kansas, six years in South Carolina and the applicable statute of limitations in Florida) from the time written proof of loss is required to be furnished.

9.05 Conformity with State Statutes: A provision of the Policy that, on the Effective Date, conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law as of the Effective Date.

9.06 Misstatement of Age or Sex: If the date of birth, Age or sex of any Covered Person has been misstated, the Initial Benefit Amount of the Policy will be of an amount that the Premium paid would have purchased at the correct date of birth, Age or sex.

9.07 Certificates: The Company will supply individual Certificates for You. This Certificate will describe:

(a) the insurance benefits;

(b) to whom benefits will be paid;

(c) any limitations of the Policy; and

(d) all other essential features of the Policy.

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

9.08 Beneficiary: The beneficiary or beneficiaries of an Insured shall be that person or persons indicated on the Insured's individual application for insurance. This application will be filed with the Policyholder. The beneficiary of an Insured Dependent, if the Policy provides Dependent Insurance, shall be the Insured.