YOUR GROUP
LONG-TERM
DISABILITY INCOME
INSURANCE PLAN

For Employees of

Clear Creek Independent School District

GROUP LONG TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South
Minneapolis, Minnesota 55401

POLICYHOLDER:	Clear Creek Independent School District
GROUP POLICY NUMBER:	70594-2LTD2011
POLICY EFFECTIVE DATE:	September 1, 2018
GOVERNING JURISDICTION:	Texas

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the group policy listed above to the **Policyholder.** The policy is available for **you** to review if **you** contact the **Policyholder** for more information. **This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate of Coverage replaces any other certificates ReliaStar Life may have given **you** under the policy.

The Certificate of Coverage summarizes and explains the parts of the policy which apply to **you.** The Certificate of Coverage is part of the group policy but by itself is not a policy. **Your** coverage may be changed under the terms and conditions of the policy.

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.

For purposes of effective dates and ending dates under the policy, all days begin at 12:01 a.m. standard time at the **Policyholder's** address and end at 12:00 midnight standard time at the **Policyholder's** address.

The policy does not replace or affect any requirements for coverage by any Workers' Compensation or state disability insurance. The policy covers disabilities due to an occupational sickness or injury.

Elizabeth M Fetterson

Registrar

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call ReliaStar Life's toll-free telephone number for information or to make a complaint at

1-800-955-7736

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

1-800-252-3439

You may write the Texas Department of Insurance
P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al número de teléfono grátis de ReliaStar Life para información o para someter una queja al

1-800-955-7736

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas
P. O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con el compania primero. Si la disputa no es resuelta, usted puede Comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solomente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

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BENEFITS AT A GLANCE

The Long Term Disability policy provides benefits to replace a portion of **your** income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before **your** disability began, subject to all policy provisions.

EMPLOYER: Clear Creek Independent School District

GROUP POLICY NUMBER: 70594-2LTD2011

ELIGIBLE CLASS(ES)
All **employees** who work in a Teacher Retirement System (TRS) eligible position in **active employment** with the **Employer** in the United States.

You must be an **employee** of the **Employer** and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
15 hours per week

WAITING PERIOD
For persons in an eligible class on or before the policy effective date: End of the month in which **you** begin **active employment.**

For persons entering an eligible class after the policy effective date: End of the month in which **you** begin **active employment.**

CREDIT PRIOR SERVICE
We will apply any prior period of work with **your Employer** toward the **waiting period** to determine **your** eligibility date.

WHO PAYS FOR THE COVERAGE
Your Employer pays the cost of **your** coverage.

WAIVER OF PREMIUM
We do not require premium payments for **your** coverage while **you** are receiving or are entitled to receive Long Term Disability payments under the policy.

ELIMINATION PERIOD
90 consecutive days.

The elimination period begins on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

MONTHLY BENEFIT
60% of **monthly earnings** to a **maximum benefit** of $7,500 per month.

Your benefit may be reduced by any **deductible sources of income** and **disability earnings.** Some disabilities may not be covered or may have limited coverage under the policy.

MONTHLY EARNINGS
Monthly earnings means **your** gross monthly income and stipends from **your Employer** in effect just prior to **your** date of disability. It includes **your** total income before taxes, and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than **your Employer.**

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the **monthly payment.**

BENEFITS AT A GLANCE

MAXIMUM PERIOD OF PAYMENT

Your Age When Disability Begins	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

REGULAR OCCUPATION PERIOD
3 Year(s)

TOTAL BENEFIT CAP
If **you** are eligible to receive payments under the policy in addition to **your monthly payment,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings.** However, if **you** are participating in a **vocational rehabilitation plan,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your monthly earnings.**

The above items are only highlights of the policy. For a full description of your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading your Certificate of Coverage.

DEFINITIONS

ACTIVE EMPLOYMENT means **you** are working for **your Employer** for earnings that are paid regularly and that **you** are performing the **material and substantial duties** of **your regular occupation. You** must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the BENEFITS AT A GLANCE.

To be in **active employment, your** work site must be one of the following:
- **Your Employer's** usual place of business.
- An alternative work site at the direction of **your Employer,** including **your** home.
- A location to which **your** job requires **you** to travel.

Normal vacation is considered **active employment.**
Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE means that all of the following are true:
- **You** visit a **doctor** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s).
- **You** receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a **doctor** whose specialty or experience is appropriate for the disabling condition(s) according to standard medical practice.
- **You** have the obligation to minimize **your** disabling condition including having corrective treatment or minor surgery.

CONTEST means that, if **we** determine **you** made a material misrepresentation in **your** application for coverage under the policy, **we** notify **you** in writing that such coverage was therefore never effective. This is subject to the INCONTESTABILITY provision.

DEDUCTIBLE SOURCES OF INCOME means income from other sources as listed in the certificate which **you** receive or are eligible to receive while **you** are disabled. This income will be subtracted from **your gross monthly payment.**

DISABILITY EARNINGS means the earnings which **you** receive while **you** are disabled and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity.**

DOCTOR means a person performing tasks that are within the limits of his or her medical license, and also meets one of the following requirements:
- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery.
- Has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.
- Is a legally qualified medical practitioner according to the **laws** and regulations of the jurisdiction where treatment occurred.

We will not recognize **you** or **your** family members, including but not limited to: spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with **you** as a **doctor** for a claim that **you** send to **us.**

ELIGIBLE SURVIVOR means **your** spouse, if living; otherwise, **your** children under age 26.

EMPLOYEE means a person who is a citizen or legal resident of the United States in **active employment** with the **Employer** in the United States.

EMPLOYER means the **Policyholder** and includes any division, subsidiary or affiliated company named in the policy.

FAMILY MEMBER means an individual who can be claimed as a dependent by **you** for federal income tax purposes.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide **you** with an income within 12 months of **your** return to work, that exceeds:
- 80% of **your indexed monthly earnings,** if **you** are working.
- 80% of **your indexed monthly earnings,** if **you** are not working.

GRACE PERIOD means the 60 day period following the premium due date during which premium payment for the policy may be made by the **Policyholder.**

GROSS MONTHLY PAYMENT means **your** benefit before any reduction for **deductible sources of income** and **disability earnings.**

DEFINITIONS

HOSPITAL CONFINED means **you** are confined as an in-patient in a **hospital, health facility or institution.** In-patient means **you** are physically confined for an overnight stay, as a registered bed patient.

HOSPITAL, HEALTH FACILITY or INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing **your** disability.

INDEXED MONTHLY EARNINGS means **your monthly earnings** adjusted on each anniversary of benefit payment by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. **Your indexed monthly earnings** may increase or remain the same, but will never decrease.

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. **We** reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while **you** are disabled and working, and in the determination of **gainful occupation.**

INJURY means a bodily **injury** that is the direct result of an accident and not related to any other cause. The **injury** must occur, and disability resulting from the **injury** must begin, while **you** are covered under the policy. **Injury** that occurs before **you** are covered under the policy will be treated as a **sickness.**

INSURED PERSON means a person who is eligible for the coverage under the policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.

LAW, PLAN or **ACT** means the original enactments of the law, plan or act and all amendments.

LEAVE OF ABSENCE means **you** are absent from **active employment** for a period of time that has been agreed to in advance in writing by **your Employer. Your** normal vacation time or any period of disability is not considered a **leave of absence.**

MATERIAL AND SUBSTANTIAL DUTIES means duties that are normally required for the performance of **your regular occupation** and that cannot be reasonably omitted or modified, except that if **you** are required to work on average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** have the capacity to work 40 hours per week.

MAXIMUM BENEFIT means the total monthly benefit amount for which **you** are insured under the policy subject to all policy provisions.

MAXIMUM CAPACITY means, based on **your** restrictions and limitations:

- During the **regular occupation period,** the greatest extent of work **you** are able to do in **your regular occupation.**
- Beyond the **regular occupation period,** the greatest extent of work **you** are able to do in any occupation for which **you** are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time **we** will make payments to **you** for any one period of disability.

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

MONTHLY EARNINGS means **your** gross monthly income from **your Employer** as stated in the BENEFITS AT A GLANCE.

MONTHLY PAYMENT means **your** benefit after any **deductible sources of income** and **disability earnings** have been subtracted from **your gross monthly payment.**

OCCUPATIONAL SICKNESS OR INJURY means a **sickness** or **injury** that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn from 20% through 80% of **your indexed monthly earnings.** Ability is based on capacity and not market availability.

PAYABLE CLAIM means a claim for which **we** are liable under the terms of the policy.

DEFINITIONS

POLICYHOLDER means the **Employer** to whom the policy is issued and who sponsors the coverage for its **employees.**

PRE-EXISTING CONDITION means any condition for which **you** have done any of the following at any time during the 3 months just prior to **your** effective date of coverage, whether or not that condition is diagnosed or misdiagnosed:

- Received medical treatment or consultation.
- Taken or were prescribed drugs or medicine.
- Received care or services, including diagnostic measures.

RECURRENT DISABILITY means a disability for which both of the following are true:

- It is caused by a worsening in **your** condition.
- It is due to the same cause(s) as **your** prior disability for which **we** made a **monthly payment.**

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, instead of how the work tasks are performed for a specific employer or at a specific location.

REGULAR OCCUPATION PERIOD is the period of time shown in the BENEFITS AT A GLANCE that begins after the elimination period.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to **insured persons** and are not funded entirely by **insured person** contributions. **Retirement plan** includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

SALARY CONTINUATION or ACCUMULATED SICK LEAVE means continued payments to **you** by **your Employer** of all or part of **your monthly earnings,** after **you** become disabled as defined by the policy. This continued payment must be part of an established plan maintained by **your Employer,** and includes **salary continuation or accumulated sick leave** or any similar **Employer** sponsored paid time off plan.

SICKNESS means illness, disease or physical condition. Disability resulting from the **sickness** must begin while **you** are covered under the policy.

VOCATIONAL REHABILITATION PLAN means a written plan that a vocational rehabilitation professional, designated by **us,** prepares in accordance with the VOCATIONAL REHABILITATION SERVICES provision of the certificate.

WAITING PERIOD means the continuous period of time (shown in the BENEFITS AT A GLANCE) that **you** must be in **active employment** in an eligible class before **you** are eligible for coverage under the policy.

WE, US and **OUR** means ReliaStar Life Insurance Company.

YOU and **YOUR** means a person who is eligible for coverage under the policy.

GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include riders, endorsements and/or amendments. It tells **you:**

- The coverage to which **you** may be entitled.
- To whom **we** will make a payment.
- The limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

If **you** are working for **your Employer** in an eligible class, the date **you** are eligible for coverage is the later of the following:

- The policy effective date.
- The day after **you** complete **your** waiting period.

WHEN COVERAGE BEGINS

When the **Policyholder** pays 100% of the cost of **your** coverage under the policy, **you** will be covered at 12:01 a.m. standard time at the **Policyholder's** address on the date **you** are eligible for coverage.

In order for **your** coverage to begin, **you** must be in **active employment. Your** coverage is subject to payment of premium.

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** or if **you** are on a covered **leave of absence.** If **you** are not in **active employment** due to **injury** or **sickness,** any increased or additional coverage will begin on the date **you** return to **active employment.**

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence,** and if premium is paid, **your** coverage may be continued beyond the date **you** are no longer in **active employment,** limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of disability coverage during an FMLA or State FML **leave of absence, your** coverage will be continued until the end of the later of:

- The leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments.
- The leave period permitted by applicable state **law.**

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence,** and if premium is paid, **your** coverage will be continued through the end of the 3 months that immediately follows the month in which **your leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law, your** coverage may be continued until the end of the later of:

- The length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence.**
- The length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence.**

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment, we** will consider such leaves to be concurrent for the purpose of determining how long **your** coverage may continue under the policy.

If **your** coverage is not continued during an FMLA or State FML **leave of absence,** and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence, your** coverage will be reinstated. **We** will not apply a new **waiting period,** or require **evidence of insurability,** or apply a new **pre-existing condition** limitation.

GENERAL PROVISIONS

If **your** coverage is not continued during a **leave of absence** for active military service, and **you** return to **active employment, your** coverage may be reinstated in accordance with USERRA and applicable state **law.**

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of the following dates:

- The date the policy is canceled.
- The date **you** are no longer in an eligible class.
- The date **your** eligible class is no longer covered.
- The end of the **Policyholder's grace period,** if the **Policyholder** does not remit premium to **us** by the end of such period.
- The last day **you** are in **active employment** except as provided under a covered **leave of absence.**

We will provide coverage for a **payable claim** that occurs while **you** are covered under the policy. Termination of the policy during a disability will have no effect on a **payable claim.**

TIME LIMITS FOR LEGAL PROCEEDINGS

You can start legal action regarding **your** claim 60 days after proof of claim has been given to **us,** and up to three years from the time proof of claim is required, unless otherwise provided under federal **law.**

REPRESENTATIONS NOT WARRANTIES

We consider any statements the **Policyholder** and **you** make in an application representations and not warranties. No statements made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless both of the following are true:

- The statement is in writing and is signed by **you.**
- A copy of that statement is given to **you** or **your** beneficiary, or **your** personal representative.

INCONTESTABILITY

Except in the case of fraud, no statement made by **you** in the application relating to **your** insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years during **your** lifetime.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

CLERICAL ERROR

Clerical error or omission by **us** or by the **Policyholder** will not:

- Prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy.
- Cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

If the **Policyholder** gives **us** information about **you** that is incorrect, **we** will do both of the following:

- Use the facts to decide whether **you** have coverage under the policy and in what amounts.
- Make a fair adjustment of the premium.

MISSTATEMENT OF AGE

If premiums applicable to **you** are based on age and **you** have misstated **your** age, there will be a fair adjustment of premiums based on **your** true age. If the benefits applicable to **you** are based on age and **you** have misstated **your** age, there will be an adjustment of said benefits based on **your** true age. **We** may require satisfactory proof of **your** age before paying any claim.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy, the **Policyholder** acts on its own behalf or as **your** agent. Under no circumstances will the **Policyholder** be deemed **our** agent.

LONG TERM DISABILITY BENEFIT INFORMATION

DEFINITION OF DISABILITY

You are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury,** both of the following are true:

- **You** are unable to perform all the **material and substantial duties** of **your regular occupation.**
- **You** have a 20% or more loss in **your indexed monthly earnings.**

After the **regular occupation period, you** are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury, you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience.

The loss of a professional or an occupational license or certification does not, in itself, constitute disability.

You must be under the **appropriate care** of a **doctor** in order to be considered disabled.

We may require **you** to be examined by one or more **doctors,** other medical practitioners or vocational experts of **our** choice. **We** will pay for this examination. **We** can require an examination as often as it is reasonable to do so. **We** may also require **you** to be interviewed by **our** authorized representative. **Your** failure to comply with this request may result in denial or termination of benefits.

ELIMINATION PERIOD

You must be continuously disabled through **your** elimination period. **Your** elimination period is as stated in the BENEFITS AT A GLANCE and is the period of continuous disability **you** must satisfy before **you** are eligible to receive benefits under the policy.

For an elimination period more than 90 days, **we** will consider **your** disability to be continuous if **your** disability stops during the elimination period for 30 days or less.

For an elimination period of 90 days, **we** will consider **your** disability to be continuous if **your** disability stops during the elimination period for 14 days or less.

For an elimination period of 31 to less than 90 days, **we** will consider **your** disability to be continuous if **your** disability stops during the elimination period for 7 days or less for each 31 days of the elimination period.

If **your** elimination period is less than 31 days, and **your** disability stops during the elimination period, **we** will not consider **your** disability to be continuous.

The days that **you** are not disabled will not count toward **your** elimination period.

The elimination period begins on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

If **you** are working while **you** are disabled, the days **you** are disabled will count toward **your** elimination period.

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when **we** approve **your** claim, providing the elimination period has been met and **you** are disabled. **We** will send **you** a **monthly payment** at the end of each month for any period for which **we** are liable.

After the elimination period, if **you** are disabled for less than 1 month, **we** will send **you** 1/30th of **your monthly payment** for each day of **your** disability.

AMOUNT OF PAYMENT

A. IF YOU ARE DISABLED AND NOT WORKING, OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED MONTHLY EARNINGS

We will follow this process to figure **your** payment:

1. Multiply **your monthly earnings** by 60%.
2. The **maximum benefit** is $7,500 per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment.**

LONG TERM DISABILITY BENEFIT INFORMATION

4. Subtract from **your gross monthly payment** any **deductible sources of income.**

The amount figured in Step 4 is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO 80% OF YOUR INDEXED MONTHLY EARNINGS

During the first 12 months of payments, the sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed monthly earnings.** If the sum exceeds 100% of **your indexed monthly earnings, we** will reduce **your** payment under the policy by the excess amount.

To determine whether the sum of **your gross monthly payment** plus **disability earnings** is less than or equal to or exceeds 100% of **your indexed monthly earnings, we** will follow this process:
1. Multiply **your monthly earnings** by 60%.
2. The **maximum benefit** is $7,500 per month.
3. Compare the answers from Step 1 and Step 2. The lesser of these two amounts is **your gross monthly payment.**
4. Add **your disability earnings** to **your gross monthly payment.**

If the answer in Step 4 above is less than or equal to 100% of **your indexed monthly earnings, your monthly payment** will be **your gross monthly payment** minus any **deductible sources of income.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

If the answer in Step 4 above is greater than 100% of **your indexed monthly earnings, we** will follow this process to figure **your monthly payment:**
   a. Add **your disability earnings** to **your gross monthly payment.**
   b. From the answer in Step a, subtract **your indexed monthly earnings.** If the result is zero or less, record **your** answer as zero.
   c. From **your gross monthly payment,** subtract the answer in Step b and any **deductible sources of income.**

The amount figured in Step c is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

After 12 months of **monthly payments, you** will receive payments based on the percentage of income **you** are losing due to **your** disability. **We** will follow this process to determine **your monthly payment:**
1. Subtract **your disability earnings** from **your indexed monthly earnings.**
2. Divide the answer in Step 1 by **your indexed monthly earnings.** The result is **your** percentage of lost earnings.
3. From **your gross monthly payment,** subtract any **deductible sources of income.**
4. Multiply the answer in Step 2 by the answer in Step 3.

The answer in Step 4 is **your monthly payment.** If this amount is less than the MINIMUM PAYMENT amount under the policy, **your** payment will be subject to the MINIMUM PAYMENT provision.

C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN 80% OF YOUR INDEXED MONTHLY EARNINGS

If **you** are working and **your disability earnings** are more than 80% of **your indexed monthly earnings,** no benefit will be payable.

We may require **you** to send proof of **your** monthly **disability earnings** each month. **We** will adjust **your** payment based on **your** monthly **disability earnings.**

As part of **your** proof of **disability earnings, we** can require that **you** send **us** appropriate financial records that **we** believe are necessary to substantiate **your** income.

LONG TERM DISABILITY BENEFIT INFORMATION

IF YOUR DISABILITY EARNINGS FLUCTUATE

If **your disability earnings** routinely fluctuate widely from month to month, **we** may average **your disability earnings** over the most recent three months to determine if **your** claim should continue.

If **we** average **your disability earnings, we** will not terminate **your** claim unless the average of **your disability earnings** from the last three months exceeds 80% of **your indexed monthly earnings.**

We will not pay **you** for any month during which **your disability earnings** exceed the amount allowable under the policy. In no event will benefits be paid beyond the **maximum period of payment.**

WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS

If **you** are eligible to receive benefits under the policy in addition to the **monthly payment,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings.** However, if **you** are participating in a **vocational rehabilitation plan,** the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 110% of **your monthly earnings.**

DEDUCTIBLE SOURCES OF INCOME

The following are **deductible sources of income:**

- The amount that **you** receive, or are eligible to receive, as disability income payments under any:
  - State compulsory benefit **act** or **law.**
  - Individual disability income plans which are wholly or partially paid for by the **Policyholder** or for which the **Policyholder** makes payroll deductions, and which are purchased on or after the effective date of the group policy.
  - Automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable.
  - Military disability benefit plan.
  - Governmental retirement system as a result of **your** job with **your Employer.**
  - Other group insurance policy.
- The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones **Act**).
- The amount **you** receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
- The amount **you** receive under any **salary continuation or accumulated sick leave** plan.
- The amount that **you:**
  - receive as disability payments under **your Employer's retirement plan;**
  - voluntarily elect to receive as retirement payments under **your Employer's retirement plan;** or
  - are eligible to receive as retirement payments when **you** reach the later of age 62 or normal retirement age, as defined in **your Employer's retirement plan.**

  Disability payments under a **retirement plan** will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

  Retirement payments will be those benefits which are paid based on **your Employer's** contribution to the **retirement plan.** Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

  Regardless of how the retirement funds from the **retirement plan** are distributed, **we** will consider the **Employer** and **insured person** contributions to be distributed simultaneously throughout **your** lifetime.

  Amounts received do not include amounts rolled over or transferred to any eligible **retirement plan. We** will use the definition of eligible **retirement plan** as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.
- The amount that **you, your** spouse and **your** children receive, or are eligible to receive, as disability payments because of **your** disability under:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**
  - Any similar **Plan** or **Act.**

LONG TERM DISABILITY BENEFIT INFORMATION

- The amount that **you** receive as retirement payments or the amount **your** spouse and **your** children receive as retirement payments because **you** are receiving retirement payments under:
  - The United States Social Security **Act.**
  - The Canada Pension **Plan.**
  - The Quebec Pension **Plan.**
  - Any similar **Plan** or **Act.**
- The amount **you** receive from any form of employment.
- The amount **you** receive from any unemployment compensation **law.**
- The amount that **you** receive, or are eligible to receive, under:
  - A workers' compensation **law.**
  - An occupational disease **law.**
  - Any other **act** or **law** with similar intent.

With the exception of retirement payments, **we** will only subtract **deductible sources of income** which are payable as a result of the same disability.

We will not reduce **your** payment by **your** Social Security retirement income if **your** disability begins after age 65 and **you** were already receiving Social Security retirement payments.

COST OF LIVING INCREASES FOR DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income **you** earn from any form of employment, once **we** have subtracted any **deductible sources of income** from **your gross monthly payment, we** will not further reduce **your** payment due to a cost of living increase from that source.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

When **we** determine that **you** may qualify for benefits for which **you** are eligible in the **deductible sources of income** provision, **we** will estimate **your** entitlement to these benefits. **We** can reduce **your** benefit under the policy by the estimated amounts if such benefits have either:

- Not been awarded or denied.
- Been denied and the denial is being appealed.

Your gross monthly payment will NOT be reduced by the estimated amount if both of the following are true:

- **You** apply for the disability payments for which **you** are eligible in the **deductible sources of income** provision and appeal **your** denial to all administrative levels **we** determine are necessary.
- **You** sign **our** form. This form states that **you** promise to pay **us** any overpayment caused by an award and **we** shall be entitled to impose a constructive trust on any such award.

If **your gross monthly payment** has been reduced by an estimated amount, **your gross monthly payment** will be adjusted when **we** receive either of the following:

- Proof of the amount awarded.
- Proof that benefits have been denied and all appeals **we** determine necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to **you.**

If **you** receive a lump sum payment from any **deductible source of income,** the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis from the date of the award over **your** expected lifetime as determined by **us.**

NON-DEDUCTIBLE SOURCES OF INCOME

We will not subtract from **your gross monthly payment** income **you** receive from the following:

- 401(k) plans.
- Profit sharing plans.
- Thrift plans.
- Tax-sheltered annuities.
- Stock ownership plans.
- Credit disability insurance.
- Non-qualified plans of deferred compensation.
- Pension plans for partners.

LONG TERM DISABILITY BENEFIT INFORMATION

- Military pension plans.
- Franchise disability income plans.
- Individual disability plans wholly paid for by the **insured person** and not through payroll deduction.
- A retirement plan from another employer.
- Individual retirement accounts (IRA).

MINIMUM PAYMENT

The minimum payment each month for a **payable claim** is the greater of:

- $100.
- 10% of **your gross monthly payment.**

We may apply this amount to recover any outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each month up to the **maximum period of payment. Your maximum period of payment** is stated in the BENEFITS AT A GLANCE, will be paid during a continuous period of disability, and will be based on **your** age at disability.

WHEN PAYMENTS END

We will stop sending **you** payments and **your** claim will end on the earliest of the following:

- The end of the **maximum period of payment.**
- The date **you** are no longer disabled under the terms of the policy.
- The date **you** fail to submit proof of continuing disability.
- The date **you** die.
- During the **regular occupation period** when **you** are able to return to work in **your regular occupation** on a **part-time basis** but **you** do not.
- After the **regular occupation period,** when **you** are able to work in any **gainful occupation** on a **part-time basis** but **you** do not.
- The date **your disability earnings** exceed 80% of **your indexed monthly earnings.**
- After 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

We will not pay a benefit for any period of disability during which **you** are incarcerated.

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any disabilities caused by, contributed by, or resulting from **your:**

- Loss of professional license, occupational license or certification.
- Commission of or attempt to commit a felony.
- Intentionally self-inflicted injuries.
- Attempted suicide, regardless of mental capacity.
- Being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **doctor.**
- Participation in a war, declared or undeclared, or any act of war.
- Active military duty.
- Active participation in a riot.
- Engaging in any illegal or fraudulent occupation, work or employment.
- Commission of a crime for which **you** have been convicted.
- Elective surgery except when required for **your appropriate care** as a result of **your injury** or **sickness.**
- Traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes.

PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if **your** disability begins in the first 12 months following the effective date of **your** coverage and **your** disability is caused by, contributed to by, or the result of a **pre-existing condition.**

LONG TERM DISABILITY BENEFIT INFORMATION

MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION

The lifetime cumulative **maximum period of payment** for all disabilities due to **mental illness,** alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related.

If **you** are confined to a **hospital, health facility or institution** at the end of the 24 month period, **we** will continue to send **you** payment(s) during **your** confinement. If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days. If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

If **you** continue to be disabled after the 24 month period, and subsequently become confined to a **hospital, health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment,** whichever occurs first.

We will not apply the **mental illness** limitation to a disability due to dementia if it is a result of stroke, trauma, viral infection or Alzheimer's disease.

CONTINUITY OF COVERAGE

If **you** are not in **active employment** due to **injury** or **sickness** or **leave of absence** on the date **your Employer** changes insurance carriers to **our** policy, and **you** were covered under the prior policy at the time **your Employer's** coverage under **our** policy became effective, **we** will provide continuity of coverage under **our** policy. In order for this provision to apply, the prior policy's coverage must be similar to **our** policy.

If **you** are not in **active employment** due to **injury** or **sickness** or **leave of absence** on the effective date of **our** policy, and **you** would otherwise be eligible to become insured under **our** policy, **we** will provide limited coverage under **our** policy. Coverage under this provision will begin on **our** policy effective date and will continue until the earliest of the following:

- The date **you** return to **active employment.**
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of **our** policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. **We** will reduce **your** payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if **you** were not covered under **your Employer's** prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under **our** policy will apply.

CONTINUITY OF COVERAGE AND PRE-EXISTING CONDITIONS

We may pay benefits if **your** disability is caused by, contributed by or results from a **pre-existing condition** if both of the following are true:

- **You** were insured by the prior policy at the time **your Employer** changed insurance carriers to **our** policy.
- **You** have been continuously covered under **our** policy from the effective date of **our** policy through the date **your** disability began.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under either **our** policy or under the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of **our** policy, but **you** do satisfy the prior policy's **pre-existing condition** provision, then both of the following apply:

- **Your monthly payment** will be the lesser of:

  – the **monthly payment** that would have been payable under the terms of the prior policy had it remained in force.
  – the **monthly payment** under **our** policy.
- Benefits will end on the earlier of:
  – the date benefits end under **our** policy, as described under the WHEN PAYMENTS END provision.
  – the date benefits would have ended under the prior policy if it had remained in force.

If **you** do not satisfy either **our** policy's or the prior policy's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy. All other provisions of **our** policy will apply.

RECURRENT DISABILITY

If **you** have a **recurrent disability,** and after **your** prior disability ended, **you** returned to work for **your Employer** for 6 months or less, **we** will treat **your** disability as part of **your** prior claim and **you** do not have to complete another elimination period. Only one **maximum period of payment** will apply when **your** disability is considered part of **your** prior claim.

Your monthly payment will be based on **your monthly earnings** as of the date of **your** initial claim. **Your** disability, as outlined above, will be subject to the same terms of the policy as **your** prior claim.

Your disability will be treated as a new claim if either of the following is true:
- **Your** current disability is unrelated to **your** prior disability.
- After **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and **you** will be required to satisfy a new elimination period. A new **maximum period of payment** will apply.

If **our** policy terminates and **you** become eligible for coverage under any other group disability plan that replaces **our** policy, **you** will not be eligible for coverage under **our** policy.

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist **you** in returning to work to the extent of **your** ability. **We** will review **your** disability claim to determine whether **you** are eligible for these services. In order to be eligible for vocational rehabilitation services and benefits, **you** must be medically able to participate in a return to work plan.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help **you** return to gainful employment. As **your** file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of **your** eligibility for these services.

If **we** determine that vocational rehabilitation services are appropriate, **we** will provide **you** with a written **vocational rehabilitation plan** developed specifically for **you.**

The **vocational rehabilitation plan** may include, but is not limited to the following services:
- Coordination with **your Employer** to assist **you** to return to work.
- Evaluation of adaptive equipment or job accommodations to allow **you** to work.
- Evaluation of possible workplace modifications which might allow **you** to return to work in **your regular occupation** or another job or occupation.
- Vocational evaluation to determine how **your** disability may impact **your** employment options.
- Job placement services, including resume preparation services and training in job-seeking skills.
- Alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy or other treatment designed to enhance **your** ability to work.

VOCATIONAL REHABILITATION BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan, you** may be eligible for an additional Vocational Rehabilitation Benefit. **We** will pay an additional benefit of 10% of **your gross monthly payment** to a maximum of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income.** However, the Total Benefit Cap will apply.

LONG TERM DISABILITY BENEFIT INFORMATION

Vocational Rehabilitation Benefits will end on the earliest of the following dates:
- The date **we** determine that **you** are no longer eligible to participate in a **vocational rehabilitation plan.**
- The date **you** are no longer participating in a **vocational rehabilitation plan.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

FAMILY MEMBER CARE EXPENSE BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan, you** will be eligible for an additional **Family Member** Care Expense Benefit if **you** are incurring expenses to provide care for a **family member** who requires personal care assistance.

We will pay a **Family Member** Care Expense Benefit of $350 per **family member** not to exceed a maximum of $5,000 per month.

The **Family Member** Care Expense Benefit will end on the earliest of the following dates:
- The date **you** are no longer incurring **family member** care expenses.
- The date **you** are no longer participating in a **vocational rehabilitation plan.**
- After 24 months of **Family Member** Care Expense Benefits have been paid for each **family member.**
- Any other date on which **monthly payments** would stop in accordance with the policy.

To receive this benefit, **you** must provide satisfactory proof that **you** are incurring a **family member** care expense.

Family member care means care or supervision of **your family member** and care is given by a licensed child-care center or a licensed caregiver who is not related to **you** by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income.** However, the Total Benefit Cap will apply.

WORKPLACE MODIFICATION BENEFIT

If **you** are disabled and are receiving a payment under the policy from **us,** a Workplace Modification Benefit may be payable to **your Employer.** Subject to the maximum amount below, **we** will reimburse **your Employer** for 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

The amount **we** pay will not exceed the lesser of the following:
- Two times **your** last **monthly payment.**
- $5,000.

You must meet both of the following requirements:
- Be disabled according to the terms of the policy.
- Have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

Your Employer must give **us** a written proposal of the proposed workplace modification. This proposal must include all of the following:
- Input from the **Employer, you** and **your doctor.**
- The purpose of the proposed workplace modification.
- The expected completion date of the workplace modification.
- The cost of the workplace modification.

We will reimburse the costs of the workplace modification when all of the following are true:
- **We** approve the proposal in writing.
- **We** receive proof from **your Employer** that the workplace modification is complete.
- **We** receive proof of the costs incurred by **your Employer** for the workplace modification.

The Workplace Modification Benefit is available on a one-time basis for each **insured person** under the policy.

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SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) times **your gross monthly payment** if, on the date of **your** death, both of the following are true:

- **Your** disability had continued for 180 or more consecutive days.
- **You** were receiving or were eligible to receive payments under the policy.

If **you** have no **eligible survivors,** payment will be made to **your** estate, unless there is none. In this case, no payment will be made.

However, **we** will first apply the Survivor Benefit to recover any overpayment that may exist on **your** claim.

RETROACTIVE BENEFIT

If **you** are receiving or entitled to receive a monthly benefit due to **your** disability, **we** will pay a Retroactive Benefit if all of the following are true:

- **You** have satisifed the elimination period.
- **You** are unable to perform the **material and substantial duties** of **your regular occupation** due to **your sickness** or **injury.**
- **You** are not working due to **your** disability, and **you** were continuously not working during **your** elimination period due to **your** disability.
- **You** were **hospital confined** for 14 consecutive days or more starting within 48 hours of the day **your** disability began.

The Retroactive Benefit is payable in a lump sum and will equal 1/30th of **your gross monthly payment** for each day **you** were disabled during **your** elimination period. This benefit will be paid only once during **your** lifetime.

CLAIM INFORMATION

NOTICE OF CLAIM

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim should be given to **us** within 30 days after the date **your** disability begins. The notice may be given to **us** at **our** home office or to **our** authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

The claim form is available from the **Policyholder** or **you** can request a claim form from **us.** If **you** do not receive the form from **us** within 15 days of **your** request, send **us** written proof of claim without waiting for the form.

You must notify **us** immediately when **you** return to work in any capacity.

FILING A CLAIM

You and **your Employer** must fill out **your** own sections of the claim form and then give it to **your** attending **doctor. Your doctor** should fill out his or her section of the form and send it directly to **us.**

PROOF OF YOUR CLAIM

You must send **us** written proof of **your** claim no later than 90 days after **your** elimination period ends. Failure to give such proof within this timeframe will not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. **You** must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at **your** expense, must show all of the following:

- That **you** are under the **appropriate care** of a **doctor.**
- The date **your** disability began.
- The cause of **your** disability.
- The appropriate documentation of **your** earnings and **your** activities.
- The extent of **your** disability, including restrictions and limitations preventing **you** from performing **your regular occupation.**
- The name and address of any **hospital, health facility or institution** where **you** received treatment, including all attending **doctors.**
- Documentation of prior disability coverage, if applicable.

In some cases, **you** will be required to give **us** authorization to obtain additional medical information, and to provide non-medical information as part of **your** proof of claim, or proof of continuing disability. **We** will deny **your** claim, or stop sending **you** payments, if the appropriate information is not submitted within 45 days of the request.

You must notify **us** immediately when **you** return to work in any capacity.

MAKING PAYMENTS

Once **your** claim has been approved, but no later than 60 days after **your** proof of claim is received, **we** will send **you** a payment at the end of each month for any period for which **we** are liable. Any balance remaining unpaid at the termination of a period of disability will be paid immediately upon receipt of **your** proof of claim.

OVERPAID CLAIMS

We have the right to recover any overpayments due to any of the following:

- Fraud.
- Any administrative error **we** make in processing a claim.
- **Your** receipt of **deductible sources of income.**

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made. **We** will not recover more money than the amount **we** paid **you.** However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.