GROUP
DISABILITY
INCOME
BENEFITS

INSURANCE INFORMATION

AMERICAN FIDELITY
a different opinion

www.americanfidelity.com

EFFECTIVE: 09/01/2020

G120-354
014608-1
TX

AMERICAN FIDELITY
a different opinion

Dear Valued Customer:

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

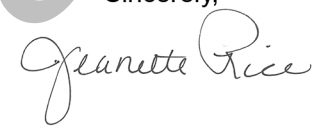
This is your new Group Disability Income Benefit certificate. Please review the documents carefully. Feel free to call us if you have any questions or are in need of assistance.

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

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

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

Sincerely,



President and Chief Operating Officer

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't you may lose your right to appeal.

American Fidelity Assurance Company

To get information or file a complaint with your insurance company:

Toll-free: 800-662-1113
Online: www.americanfidelity.com
E-mail: customersupport@americanfidelity.com
Mail: 9000 Cameron Parkway
Oklahoma City, OK 73114

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A
PO Box 149091
Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, por sun ombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presenter una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

American Fidelity Assurance Company

Para obtener información o para presenter una queja ante su compañía de seguros:

Teléfono gratuito: 800-662-1113
En linea: www.americanfidelity.com
Correo electrónico:
customersupport@americanfidelity.com
Dirección postal: 9000 Cameron Parkway
Oklahoma City, OK 73114

El Departmento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico:
ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

AMERICAN FIDELITY
a different opinion

9000 CAMERON PARKWAY, OKLAHOMA CITY, OKLAHOMA 73114

CERTIFICATE OF INSURANCE

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

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

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

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

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

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

Jeanette Rice
President and Chief Operating Officer

Christopher T. Kenney
Secretary

NON PARTICIPATING GROUP DISABILITY INCOME INSURANCE CERTIFICATE

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

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

FP-TX-D

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TC

SCHEDULE OF BENEFITS
PLAN: 014608-1

POLICYHOLDER: GARLAND INDEPENDENT SCHOOL DISTRICT

POLICY NUMBER: G120-354

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

ELIGIBILITY: All permanent employees currently specified by the employer, association, or collective bargaining agreement.

DISABILITY BENEFIT: 35% of Your Monthly Compensation not to exceed:

(1) a maximum covered Monthly Compensation of $28,571.00; and
(2) the amount for which premium is being paid.

If applicable, Your Disability Benefit will be reduced by Deductible Sources of Income as outlined in Section 3.

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

MAXIMUM DISABILITY PERIOD:

Injury:

Age	Maximum Benefit Period
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
Age 60	60 months, or to SSNRA*, whichever is greater
Age 61	48 months, or to SSNRA*, whichever is greater
Age 62	42 months, or to SSNRA*, whichever is greater
Age 63	36 months, or to SSNRA*, whichever is greater
Age 64	30 months, or to SSNRA*, whichever is greater
Age 65	24 months, or to SSNRA*, whichever is greater
Age 66	21 months, or to SSNRA*, whichever is greater
Age 67	18 months, or to SSNRA*, whichever is greater
Age 68	15 months, or to SSNRA*, whichever is greater
Age 69 or older	12 months, or to SSNRA*, whichever is greater

*Age at which You are entitled to unreduced Social Security benefits based on current Social Security Amendments.

Sickness:

Age	Maximum Benefit Period
Less than age 60	To Social Security Normal Retirement Age (SSNRA)*
Age 60	60 months, or to SSNRA*, whichever is greater
Age 61	48 months, or to SSNRA*, whichever is greater
Age 62	42 months, or to SSNRA*, whichever is greater
Age 63	36 months, or to SSNRA*, whichever is greater
Age 64	30 months, or to SSNRA*, whichever is greater
Age 65	24 months, or to SSNRA*, whichever is greater
Age 66	21 months, or to SSNRA*, whichever is greater
Age 67	18 months, or to SSNRA*, whichever is greater
Age 68	15 months, or to SSNRA*, whichever is greater
Age 69 or older	12 months, or to SSNRA*, whichever is greater

*Age at which You are entitled to unreduced Social Security benefits based on current Social Security Amendments.

ELIMINATION PERIOD:

Injury: 7 days

Sickness: 7 days

MAXIMUM MENTAL ILLNESS PERIOD: Up to 2 years not to exceed the Maximum Disability Period.

SPECIAL CONDITIONS PERIOD: 2 years not to exceed the Maximum Disability Period.

PHYSICIAN EXPENSE BENEFIT:

Injury: $150.00 per Injury

HOSPITAL CONFINEMENT BENEFIT: 1 times the Disability Benefit that will not be reduced by Deductible Sources of Income.

The Hospital Confinement Benefit will be payable on the first day You are confined as a patient in a Hospital for the days of that confinement. The remainder of Your Elimination Period will be waived.

MAXIMUM HOSPITAL CONFINEMENT PERIOD: 60 days

ADJUSTMENT WITH SICK LEAVE OR OTHER SALARY OR WAGE CONTINUANCE PLAN (See Section 3) EXTENDING BEYOND THE FOLLOWING NUMBER OF CALENDAR DAYS OF DISABILITY: 365 days

SB

SECTION 1
DEFINITIONS

ACTIVE EMPLOYMENT means that You are:

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL means a place that is licensed and operated pursuant to law which:

(a) provides care and treatment for ill and injured persons on an inpatient basis;
(b) provides facilities for medical, diagnostic and surgical care;
(c) provides 24-hour-a-day nursing care by or under the supervision of a registered nurse; and
(d) is supervised by a staff of one or more Physicians; or
(e) is accredited by the Joint Commission on the Accreditation of Hospitals.

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

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

INJURY means physical harm or damage to the body sustained by You which:

(a) results directly from an accidental bodily injury;
(b) is independent of disease or bodily infirmity; and
(c) takes place while Your coverage is in force.

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

MONTHLY COMPENSATION means:

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

in effect on the date Disability began.

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

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

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

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

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

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

POLICYHOLDER means the Employer who holds the Policy.

REGULAR AND APPROPRIATE CARE means:

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

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

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

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

DEF-TX-D

SECTION 2
ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who:

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

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

EFFECTIVE DATE: WHEN COVERAGE BEGINS

Your coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date We approve the written application, if You:

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

If You are not on Active Employment due to an Injury or Sickness when Your coverage would otherwise take effect, coverage will take effect on the first of the month following the date You return to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Disability that begins after the Effective Date of such change, subject to all the provisions of the Policy.

Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

EFF-VOL

SECTION 3
DISABILITY BENEFITS

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

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

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

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

Disability Payments will be provided for only one Disability when:

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

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

Disability will be considered to have begun on the date You were seen and treated by a Physician following continuous cessation of work.

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

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

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

Any Disability which begins after termination of coverage:

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

BEN

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

For the first 12 months You are Disabled due to a covered Disability and not working, we will pay the Disability Benefit described in the Schedule.

After 12 months, Your Disability Payment will be the Disability Benefit described in the Schedule less any Deductible Sources of Income You receive or are entitled to receive.

BNMD

DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include all of the following:

(a) Other group disability income.
(b) Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits.

(c) United States Social Security Act or similar plan or act, including any amounts due Your dependent(s) on account of Your Disability.
(d) State Disability.
(e) Unemployment compensation.
(f) Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond the period stated in the Schedule.

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

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

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

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

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

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

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

LUMP SUM RETIREMENT WITHDRAWALS: If You have the option of taking retirement benefits on a monthly basis but choose to receive retirement benefits on a lump sum basis or withdraw Your retirement contributions, We will assume You are receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS: The Disability Payment will not be reduced due to a cost of living increase if the increase takes effect after the onset of Disability and while benefits are payable under the Policy.

MINIMUM DISABILITY BENEFIT: The Disability Payment payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule.

DSI

IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING

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

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

During the first 24 months of payments, while Disabled and working, Your Disability Payment will not be reduced as long as the Disability Earnings plus the gross Disability Benefit does not exceed 80% of Your Monthly Compensation.

If the Disability Earnings plus the gross Disability Benefit exceeds 80% of Your Monthly Compensation, the Disability Payment will be reduced by the amount exceeding 80% of Your Monthly Compensation.

After 24 months of payments, while Disabled and working, You will receive payments based on the percentage of Monthly Compensation You are losing due to Your Disability computed as follows:

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

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

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

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

BENW1

FAMILY CARE BENEFIT

If You are Disabled and Working, qualify to receive a Disability Payment from Us, and have one or more eligible Family Members, You may be eligible to receive a Family Care Benefit. We will provide a Family Care Benefit of up to 25% of Your Monthly Disability Benefit provided the total of Your Disability Earnings, the gross Disability Benefit, and the Family Care Benefit do not exceed 100% of Your Monthly Compensation.

The Family Care Benefit:

(a) will not exceed the expenses incurred for the care of eligible Family Members; and
(b) will be reduced by the amount exceeding 100% of Your Monthly Compensation if the total of Your Disability Earnings, Your gross Disability Benefit, and the Family Care Benefit exceed 100% of Your Monthly Compensation.

An eligible Family Member is:

(a) Your child (natural, step, or adopted) living in Your household and under age 13; or
(b) Your family member who is:

    (1) living in Your household;
    (2) dependent upon You for support; and
    (3) in need of supervision or assistance due to physical or mental incapacity.

Care for Your eligible Family Member must be provided by a licensed childcare provider or a licensed caregiver who is not related to You by blood or marriage.

Payment of the Family Care Benefit will end on the earlier of the following:

(a) the date You no longer incur Family Member expenses; or
(b) the date You no longer qualify as Disabled and Working; or
(c) the date Disabled and Working benefits have been paid for a total of 24 months.

FAMCARE

TERMINATION OF BENEFITS

Disability Payments will end on the earliest of these dates:

(a) the date You are no longer Disabled;
(b) the date Your Disability Earnings are more than 80% of Your Monthly Compensation; Disability Earnings means the gross monthly earnings You receive while Disabled and Working;
(c) the date You die;
(d) the last day Disability Payments are made according to the Schedule;
(e) the date You fail to provide Us with written proof of Your Disability, satisfactory to Us;

(f) the date You cease to be under the Regular and Appropriate Care of a Physician, refuse to undergo an examination by a Physician, or refuse vocational testing when We require such examination or testing;
(g) the date You refuse to receive medical treatment that is generally acknowledged by Physicians to cure or improve Your condition so as to reduce its disabling effect;
(h) the date You refuse to try or attempt to work with the assistance of:

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

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

TERMBEN

PHYSICIAN EXPENSE BENEFIT

If You receive personal treatment by a Physician due to an Injury, the Physician Expense Benefit shown in the Schedule will be paid if a claim for no other benefit is made under the Policy.

PHY

HOSPITAL CONFINEMENT BENEFIT

If You are confined as a patient in a Hospital due to an Injury or Sickness, a Hospital Confinement Benefit will be paid for each day You are charged room and board. This benefit is subject to the following:

(a) the Hospital confinement must be at least 18 continuous hours in duration;
(b) the benefit will be equal to the Hospital Confinement Benefit shown in the Schedule and will be pro rated based upon the number of days You are Hospital confined;
(c) Hospital Confinement Benefit is limited to the Maximum Hospital Confinement Period shown in the Schedule;
(d) the Hospital Confinement Benefit will be paid in lieu of the Disability Benefit payable during the Maximum Hospital Confinement Period; and
(e) the period for which Hospital Confinement Benefits are paid will be included in computing the Maximum Disability Period.

HC

WAIVER OF PREMIUM

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

(a) Your satisfaction of the Elimination Period; or
(b) 90 days of continuous Disability,

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

Waiver of Premium will continue until:

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

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

WP2

SECTION 4
LIMITATIONS AND EXCLUSIONS

MENTAL ILLNESS LIMITED BENEFIT

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

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

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

MI1

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

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

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

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

MI-DEF

SPECIAL CONDITIONS LIMITED BENEFIT

If You are Disabled due to a Special Condition and You are under the Regular and Appropriate Care of a Physician, Disability Payments will be provided for the Special Conditions Period shown in the Schedule.

Special Conditions means:

(a) Chronic Fatigue Syndrome.
(b) Fibromyalgia.
(c) Environmental allergic illness, including, but not limited to sick building syndrome and multiple chemical sensitivity.
(d) Self-Reported Symptoms. Self-Reported Symptoms means the manifestations of Your condition that You tell Your Physician that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of Self-Reported Symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
(e) Any disease, disorder, accident or injury of the neck or back not resulting in hemiplegia, paraplegia, or quadriplegia.

SP-CON

ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT

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

ALC1

PRE-EXISTING CONDITION LIMITATION

If Disability is caused by or resulting from a Pre-Existing Condition and begins before You have been continuously covered under the Policy for 12 months, no Disability Benefit will be payable.

PE3

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

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

during the 3-month period immediately before the Effective Date of Your coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

PEDEF

EXCLUSIONS

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

(a) Intentionally self-inflicted Injury while sane or insane.
(b) An act of war, declared or undeclared.
(c) Injury sustained or Sickness contracted while in the service of the armed forces of any country.
(d) Committing a felony.
(e) Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which You are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.
(f) Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which You are entitled to Workers' Compensation*.

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

EXC

SECTION 5
TERMINATION OF INSURANCE

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

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

If:

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

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

Termination of the Policy will have no effect on Disability Payments that began before such termination.

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

We, or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

LEAVE OF ABSENCE

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

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SECTION 6
PREMIUM CALCULATION AND PAYMENT

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

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

(a) Our Home Office; or
(b) an authorized entity of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 60 days prior notice is given to the Policyholder.

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

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SECTION 7
GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

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

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

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

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

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

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

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

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

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

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

NOTICE OF CLAIM: Written Notice of Claim must be given to Us at 9000 Cameron Parkway, Oklahoma City, Oklahoma, 73114, or to Our agent. Such Notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give Notice within that time, the claim may not be denied or reduced due to the delay.

PROOF OF LOSS: Proof of Loss must be given to Us within 90 days after the loss. Late proof may be accepted if:

(a) it was not reasonably possible to give Proof in that time; and
(b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at Your expense, must show:

(a) that You are under the Regular and Appropriate Care of a Physician;
(b) the date Your Disability began;
(c) the cause of Your Disability;
(d) the appropriate documentation of Your Monthly Compensation;
(e) the extent of Your Disability, including restrictions and limitations preventing You from performing Your Regular Occupation; and

(f) the name and address of any Hospital or institution where You received treatment, including all attending Physicians.

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

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

TIME OF PAYMENT OF CLAIMS: All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written Proof. Benefits for any other covered loss will be paid as soon as We receive written proof of such Proof of Loss.

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

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

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

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

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

CERTIFICATES: An Individual Certificate will be issued to You. The Certificate will describe:

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

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

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

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

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

CLAIM OVERPAYMENT: We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You may be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

(a) recover such overpayments from:

(1) You;
(2) any other person to or for whom payment was made;
(3) Your estate;
(4) Your beneficiary;
(5) any other organization; and
(6) any other insurance company;

(b) reduce or offset against any future benefits payable to You, Your Estate, Your Survivors, or Your Beneficiary, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
(c) refer Your unpaid balance to a collection agency; and
(d) pursue and enforce all legal and equitable rights in court.

GENPROV

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

(THIS FORM IS NOT A PART OF YOUR CONTRACT)

NOTICE OF THE RIGHT TO APPEAL

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

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

FACTS WHAT DOES AMERICAN FIDELITY CORPORATION (AFC) DO WITH YOUR PERSONAL INFORMATION?

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?	The types of information we collect and share depend on the product or service you have with us. This information can include: • Social Security number and income • account transactions and medical information • insurance claim history and employment information

How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons AFC chooses to share; and whether you can limit the sharing.

Reasons we can share your personal information	Does AFC share?	Can you limit this sharing?
For our everyday business purposes – Such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report it to credit bureaus	Yes	No
For our marketing purposes – To offer our own products and services to you	Yes	No
For our affiliates to market to you	No	We don't share your information for this purpose
For our affiliates' everyday business purposes – Information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – Other information about your insurability	Yes	No
For our affiliates' everyday business purposes – Other information about your creditworthiness	No	We don't share your information for this purpose
For joint marketing with other financial companies	No	We don't share your information for this purpose
For non-affiliated third parties to market to you	No	We don't share your information for this purpose

Questions?	Call 1-866-554-4722 or go to www.americanfidelity.com.

Who we are	
Who is providing this notice?	American Fidelity Corporation (AFC)
What we do	
How does AFC collect my personal information?	We collect your personal information, for example, when you: • Provide information to us in the application process. • Transact business with us, our affiliates, or others, such as additional products or services purchased, etc. • Have information provided by your employer, group plan sponsor, or association for any group product you may have. • Have information provided by consumer reporting agencies, such as credit relationships and history. • Have information provided from other sources outside AFC such as medical information, motor vehicle reports, etc. • Visit AFC's non-public Online Service Center Web Site.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Sharing for non-affiliated third parties to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and non-financial companies. AFC's affiliates include: • American Public Life Insurance Company • American Fidelity Administrative Services, LLC • Health Services Administration, LLC • American Fidelity Assurance Company • American Fidelity General Agency, Inc. • American Fidelity Property Company • American Fidelity Securities, Inc. • Balliet's, LLC
Non-affiliated third parties	Companies not related by common ownership or control. They can be financial and non-financial companies. • AFC does not share with non-affiliates so they can market to you.
Joint marketing	A formal agreement between non-affiliated third parties that together market financial products or services to you. • AFC does not jointly market financial products or services.

Other important information
AFC maintains appropriate physical, electronic, and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. Physical and electronic files are kept in secure areas. We educate our employees about the importance of confidentiality and customer privacy. We also enforce employee privacy responsibilities. We apply the same privacy policies to former customers that we apply to current customers.