

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

Group Policyholder: Uintah County

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on July 1, 2007, and on the same day of each month after that. Policy anniversaries will be each June 1; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is June 1, 2007.

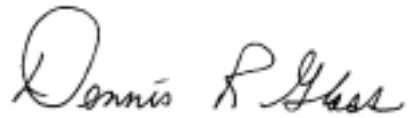
The Accidental Death and Dismemberment coverage in this Policy is subject to a war exclusion and other limitations.

This is a nonparticipating Policy.

Please refer to the Policy provisions for more information.]



Secretary



President

GROUP INSURANCE POLICY
No. GL 000403001033
PROVIDING
VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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SCHEDULE OF INSURANCE

The amount of an Insured Person's insurance is determined from the following table. The initial amount of coverage is the amount which applies to an Insured Person's Class on the date his or her coverage takes effect. An Insured Person may become eligible for increases in the amount of insurance in accord with the table. Any such increase will take effect on the latest of:

- (1) the first day of the Insurance Month which coincides with or follows the date on which the Insured Person becomes eligible for the increase; provided he or she is Actively at Work on that day; or
- (2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect.

Any decrease will take effect on the day of the change; whether or not the Insured Person is Actively at Work.

CLASSIFICATION

Class 1	All Full-Time Uintah County Commissioners
Class 2	Elected Officials and All Full-Time Uintah County Department Heads
Class 3	All Other Full-Time Employees of Uintah County

WAITING PERIOD:

For Classes 1 and 2: None (For date insurance begins, refer to "Effective Dates of Coverages" section)

For Class 3: 30 days of continuous Active Work (For date insurance begins, refer to "Effective Dates of Coverages" section):

SCHEDULE OF INSURANCE (CONTINUED)

VOLUNTARY AD&D INSURANCE - EMPLOYEE ONLY PLAN

PRINCIPAL SUM FOR INSURED PERSON

Class 1 \$180,000

Voluntary AD&D Insurance will be reduced as follows:

- At age 70, benefits will reduce by 35% of the original amount;
- At age 75, benefits will reduce by an additional 25% of the original amount; and
- At age 80, benefits will reduce by an additional 15% of the original amount.

Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Voluntary AD&D Insurance at age 70 or older, the above age reductions will apply to the maximum amount of insurance for which he or she is eligible.

Basic Annual Earnings means the Insured Person's annual base salary or annualized hourly pay from the Group Policyholder before taxes on the determination date. The determination date is the last day worked just prior to the loss.

It also includes:

1. commissions averaged over the 12 months just prior to the determination date or over the actual period of employment with the Group Policyholder just prior to that date, if shorter.

It does **not** include bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Group Policyholder. It will not exceed the amount shown in the Group Policyholder's financial records or the amount for which premium has been paid, whichever is less.

Insured Persons are required to make contributions for Voluntary AD&D Insurance.

SCHEDULE OF INSURANCE (CONTINUED)

VOLUNTARY AD&D INSURANCE - EMPLOYEE ONLY PLAN

PRINCIPAL SUM FOR INSURED PERSON

Class 2 \$200,000

Voluntary AD&D Insurance will be reduced as follows:

- At age 70, benefits will reduce by 35% of the original amount;
- At age 75, benefits will reduce by an additional 25% of the original amount; and
- At age 80, benefits will reduce by an additional 15% of the original amount.

Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Voluntary AD&D Insurance at age 70 or older, the above age reductions will apply to the maximum amount of insurance for which he or she is eligible.

Basic Annual Earnings means the Insured Person's annual base salary or annualized hourly pay from the Group Policyholder before taxes on the determination date. The determination date is the last day worked just prior to the loss.

It also includes:

1. commissions averaged over the 12 months just prior to the determination date or over the actual period of employment with the Group Policyholder just prior to that date, if shorter.

It does **not** include bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Group Policyholder. It will not exceed the amount shown in the Group Policyholder's financial records or the amount for which premium has been paid, whichever is less.

Insured Persons are required to make contributions for Voluntary AD&D Insurance.

SCHEDULE OF INSURANCE (CONTINUED)

VOLUNTARY AD&D INSURANCE - EMPLOYEE ONLY PLAN

PRINCIPAL SUM FOR INSURED PERSON

Class 3

\$210,000

Voluntary AD&D Insurance will be reduced as follows:

- At age 70, benefits will reduce by 35% of the original amount;
- At age 75, benefits will reduce by an additional 25% of the original amount; and
- At age 80, benefits will reduce by an additional 15% of the original amount.

Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Voluntary AD&D Insurance at age 70 or older, the above age reductions will apply to the maximum amount of insurance for which he or she is eligible.

Basic Annual Earnings means the Insured Person's annual base salary or annualized hourly pay from the Group Policyholder before taxes on the determination date. The determination date is the last day worked just prior to the loss.

It also includes:

1. commissions averaged over the 12 months just prior to the determination date or over the actual period of employment with the Group Policyholder just prior to that date, if shorter.

It does **not** include bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Group Policyholder. It will not exceed the amount shown in the Group Policyholder's financial records or the amount for which premium has been paid, whichever is less.

Insured Persons are required to make contributions for Voluntary AD&D Insurance.

DEFINITIONS

ACTIVE WORK or **ACTIVELY AT WORK** means an employee's full-time performance of all customary duties of his or her occupation at:

- (1) the **GROUP POLICYHOLDER'S** place of business; or
- (2) any other business location where the employee is required to travel.

Unless disabled on the prior workday or on the day of absence, an employee will be considered **Actively at Work** on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) an excused or emergency leave of absence (except a medical leave).

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation, whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY OR DATE means at 12:01 A.M., Standard Time, at the **GROUP POLICYHOLDER'S** place of business; when used with regard to eligibility dates and effective dates. It means 12:00 midnight, Standard Time, at the same place; when used with regard to termination dates.

FULL-TIME EMPLOYEE means an employee of the **GROUP POLICYHOLDER**:

- (1) whose employment with the **GROUP POLICYHOLDER** is the employee's principal occupation;
- (2) who is not a temporary or seasonal employee; and
- (3) who is regularly scheduled to work at such occupation at least 20 hours each week.

GROUP POLICYHOLDER means the person, partnership, corporation, or trust as shown on the Title Page of this Policy.

INSURANCE MONTH means that period of time:

- (1) beginning at 12:01 A.M. Standard Time, at the **GROUP POLICYHOLDER'S** place of business on the first day of any calendar month; and
- (2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a **PERSON** for whom the coverages provided by this Policy are in effect.

PERSON means a **FULL-TIME EMPLOYEE** or **ELECTED OFFICIAL** of the **GROUP POLICYHOLDER**:

- (1) who is a member of an employee class which is eligible for coverage under this Policy; and
- (2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by this Policy on Insured Persons.

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

POLICY means this Group Insurance Policy issued by the Company to the Group Policyholder.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) this Policy and the Group Policyholder's application (a copy is attached); and
- (2) the Insured Persons' enrollment cards, if any.

All statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by this Policy; unless:

- (1) it is contained in a written statement signed by that Insured Person; and
- (2) a copy of the statement is furnished to the Insured Person or Beneficiary.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in this Policy.

INCONTESTABILITY. Except for the non-payment of premiums, the Company may not contest the validity of this Policy as to any Insured Person after it has been in force for two years during his or her lifetime. This clause will not affect the Company's right to contest claims made for disability, accidental death, or accidental dismemberment benefits.

NONPARTICIPATION. This Policy will not be entitled to share in the surplus earnings of the Company.

BASIS OF RESERVE. The reserve for this Policy will not be less than the reserve computed using:

- (1) the 1970 Intercompany Group Life Disability Valuation Table; and
- (2) interest at not less than three percent per annum.

INFORMATION TO BE FURNISHED. The Group Policyholder may be required to furnish any information needed to administer this Policy. Clerical error by the Group Policyholder will not:

- (1) affect the amount of insurance which would otherwise be in effect; or
- (2) continue insurance which otherwise would be terminated.

Once an error is discovered, an equitable adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the twelve month period which precedes the date the Company receives proof such an adjustment should be made.

The Company may inspect any of the Group Policyholder's records which relate to this Policy.

MISSTATEMENT OF AGE. If an Insured Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon the person's correct age.

CERTIFICATES. The Group Policyholder will be furnished with individual Certificates for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

CONFORMITY WITH STATE STATUTES. If any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

WORKER'S COMPENSATION. This Policy is not to be construed to provide benefits required by Worker's Compensation laws.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:

- (1) this Policy and the Group Policyholder's application (a copy is attached);
- (2) the Participating Employer's participation agreement; and
- (3) the Insured Persons' enrollment cards, if any.

All statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by this Policy; unless:

- (1) it is contained in a written statement signed by that Insured Person; and
- (2) a copy of the statement is furnished to the Insured Person or Beneficiary.

Only an Officer of the Company may change this Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an Officer of the Company. Any change so made will be binding on all persons referred to in this Policy.

INCONTESTABILITY. Except for the non-payment of premiums, the Company may not contest the validity of this Policy as to any Insured Person after it has been in force for two years during his or her lifetime. This clause will not affect the Company's right to contest claims made for disability, accidental death, or accidental dismemberment benefits.

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BASIS OF RESERVE. The reserve for this Policy will not be less than the reserve computed using:

- (1) the 1970 Intercompany Group Life Disability Valuation Table; and
- (2) interest at not less than three percent per annum.

INFORMATION TO BE FURNISHED. The Group Policyholder and Participating Employers may be required to furnish any information needed to administer this Policy. Clerical error by the Group Policyholder or Participating Employer will not:

- (1) affect the amount of insurance which otherwise would be in effect; or
- (2) continue insurance which otherwise would be terminated.

Once an error is discovered, an equitable adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the twelve month period which precedes the date the Company receives proof such an adjustment should be made.

The Company may inspect any of the Group Policyholder's or Participating Employers' records which relate to this Policy.

MISSTATEMENT OF AGE. If an Insured Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon the person's correct age.

CERTIFICATES. The Group Policyholder will be furnished with individual Certificates for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

CONFORMITY WITH STATE STATUTES. If any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

WORKER'S COMPENSATION. This Policy is not to be construed to provide benefits required by Worker's Compensation laws.

PROVISIONS APPLICABLE TO PARTICIPATING EMPLOYERS

A Participating Employer has no rights under this Policy except as provided in this Section. The Participating Employer will be responsible for all premiums payable with respect to any of its Employees who are Insured Persons under this Policy.

PARTICIPATING EMPLOYER means an employer who has been approved by the Company for participation in the coverage provided by this Policy. The following are Participating Employers:

Tri-County Health Dept.
Uintah Care Center

EFFECTIVE DATE. As it applies to any Participating Employer, the Effective Date of this Policy will be the later of:

- (a) the date this Policy is issued;
- (b) the first day of the Insurance Month following the Company's approval of the employer's Participation Agreement; or
- (c) a date agreed upon by the Company, the Participating Employer, and the Group Policyholder.

TERMINATION: Coverage under this Policy will cease as to the employees of any Participating Employer on the date the Participating Employer:

- (a) no longer meets the definition of a Participating Employer;
- (b) suspends active business operations or is placed in bankruptcy or receivership;
- (c) dissolves or merges;
- (d) is excluded from coverage by Policy amendment; or
- (e) stops paying premiums as required by this Policy.

If an employer ceases to be a Participating Employer, it may not be a Participating Employer again; until it is re-approved as such by the Company.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL INSURANCE

ELIGIBILITY. A Person becomes eligible for the coverage provided by this Policy on the later of:

- (1) the Policy's date of issue; or
- (2) the date the Waiting Period is completed.

WAITING PERIOD. (See Schedule of Insurance)

EFFECTIVE DATE. Personal Insurance becomes effective on the latest of:

- (1) (a) for Classes 1 and 2, the date the Person becomes eligible for the coverage;
(b) for Class 3, the first day of the Insurance Month coinciding with or next following the date the Person becomes eligible for the coverage;
- (2) the date the Person resumes Active Work, if not Actively at Work on the day he or she becomes eligible; or
- (3) the date the Person makes written application for Personal Insurance; and signs:
 - (a) a payroll deduction order, if Insured Persons pay any part of the Policy premium;
or
 - (b) an order to pay premiums from the Person's Section 125 Plan account, if Employer contributions are made through a Section 125 Plan.

EXCEPTION. If an Insured Person's coverage terminates due to an approved leave of absence or military leave, the Company will waive any Waiting Period or evidence of insurability requirement upon his or her return; provided:

- (1) the Person applies or is enrolled within 31 days after resuming Active Work; and
- (2) the reinstated amount of insurance does not exceed the amount which terminated.

INDIVIDUAL TERMINATIONS

An Insured Person's coverage will terminate on the earliest of:

- (1) the date this Policy terminates;
- (2) the last day of the Insurance Month in which the Insured Person requests termination;
- (3) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
- (4) the date the Insured Person ceases to be in a class of employees which is eligible for coverage under this Policy;
- (5) with respect to any particular insurance benefit, the date the portion of the Policy providing that benefit terminates;
- (6) the date the Insured Person's employment with the Group Policyholder or Participating Employer terminates; or
- (7) the date the Insured Person enters the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If the Insured Person sends proof of military service, the Company will refund any unearned premium.)

Ceasing Active Work results in termination of insurance; but coverage may be continued as follows:

- (1) If the Insured Person is disabled due to illness or injury, then insurance may be continued until the earlier of:
 - (a) the date the Insured Person is no longer disabled; or
 - (b) the date the Policy terminates or Participating Employer's participation ends; provided premium payments are made on his or her behalf.
- (2) If the Insured Person ceases work due to a temporary lay off, an approved leave of absence, or a military leave; then coverage may be continued:
 - (a) for three Insurance Months after the lay off or leave begins;
 - (b) provided premium payments are made on his or her behalf

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at the Company's Group Insurance Service Office. The premium must be paid in U.S. dollars.

PREMIUM RATE CHANGE. The Company may change any premium rate on any of the following dates:

- (1) the date this Policy's terms are changed;
- (2) the date the Company's liability is changed due to a change in federal, state or local law;
- (3) the date the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy;
- (4) the date any coverage for one or more classes ceases to be provided under this Policy;
- (5) the date the number of Insured Persons changes by 25% or more from the enrollment on the date this Policy took effect, or the most recent Rate Guarantee Date expired, if later; or
- (6) on any premium due date on or after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the sum of the products obtained by multiplying each rate shown in the Premium Rate Schedule by the amount of insurance to which the rate applies.

Premium adjustments will not be pro-rated daily. Instead, premium will be adjusted as follows.

- (1) When an Insured Person's insurance or increase takes effect, premium will be charged from the monthly due date coinciding with or next following that change.
- (2) When all or part of an Insured Person's insurance terminates, the applicable premium will cease on the monthly due date coinciding with or next following that termination.
- (3) When premiums are paid other than monthly, increases or decreases will result in adjustment from the premium due date coinciding with or next following that change.

The above manner of charging premium is for accounting purposes only. It will not extend coverage beyond a date it would have otherwise terminated. Each premium payment will include any adjustments in past premiums, which are needed due to changes that have not yet been taken into account. If a premium adjustment involves a return of unearned premium, the refund will be limited to the prior 12-month period.

PREMIUM RATE SCHEDULE

Monthly Voluntary AD&D Rate

Employee Only Coverage	\$0.03 per \$1,000 of insurance
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The above rates are guaranteed until 06/01/09; unless any of the Policy's terms are changed:

- (1) as agreed upon by the Group Policyholder and the Company; or
- (2) as a result of a change in state or federal law which affects this Policy.

After that, any premium increase will be as shown in the renewal letter.

GRACE PERIOD

A grace period of 31 days from the due date will be allowed for the payment of each premium after the first. During the grace period, the Policy will remain in effect. However, the Group Policyholder will remain liable to the Company for payment of a pro rata premium for the time the Policy was in force during the grace period.

POLICY TERMINATION

TERMINATION BY THE COMPANY. To terminate this Policy, the Company must give the Group Policyholder at least 31 days' advance written notice of its intent to do so. Until the premium rate has been in effect for at least twelve months, the Company can terminate coverage only if:

- (1) the total number of Insured Persons is less than 10;
- (2) all of the premium is paid by Group Policyholder and less than 100% of those eligible for the coverage are insured; or
- (3) part of the premium is paid by Insured Persons and less than 100% of those eligible for the coverage are insured. (This part 3 will not apply to Voluntary Accidental Death and Dismemberment Insurance).

After the premium rate has been in effect for at least 12 months, the Company can terminate coverage on any premium due date, by giving 31 days' advance written notice.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Coverage will then terminate:

- (1) on the date the Company receives the notice; or
- (2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. This Policy will terminate (without any action on the Company's part) on the day before the due date of any premium which remains unpaid at the end of the Grace Period.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If no named Beneficiary survives the Insured Person, payment will be made to the Insured Person's estate or in accord with the Facility of Payment section. The right of a Beneficiary to receive any such amount is subject to the Facility of Payment section of this Policy.

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable as a result of his or her death will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

- (1) surviving spouse; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving sibling or siblings in equal shares; or, if none
- (5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has. Such payment will release the Company from any further obligation for the death benefit.

If the person who would otherwise receive payment dies:

- (1) within 15 days of the Insured Person's death; and
- (2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. An Insured Person's Beneficiary will be as shown on his or her enrollment card, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

CHANGING THE BENEFICIARY. Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT

If any benefit under this Policy becomes payable to an Insured Person's estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

- (1) a person who has assumed the care and support of the Insured Person or Beneficiary;
- (2) a person who has incurred expense as a result of the Insured Person's last illness or death;
- (3) the personal representative of the Insured Person's estate; or
- (4) any person related by blood or marriage to the Insured Person.

No payment made to anyone named above may exceed \$1,000. Any payment made in good faith under this Section will fully discharge the Company to the extent of the payment.

SETTLEMENT OPTIONS

INSTALLMENTS. All or part of any death or dismemberment benefit may be received in installments by making written election to the Company.

ELECTION. While living, an Insured Person may direct the Company to pay any death or dismemberment benefit in installments. If no such direction is in effect at the time of the Insured Person's death, the person who is to receive payment may make such an election.

CONDITIONS. Any such election must comply with the Company's practices at the time it is made. The amount applied under a settlement option must be at least \$2,000. It must be sufficient to provide a payment of at least \$20 per month.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

DEATH OR DISMEMBERMENT BENEFIT. The Company will pay the benefit listed below, if:

- (1) an Insured Person or a Dependent sustains a covered accidental bodily injury while insured under this provision; and
- (2) that injury directly causes one of the following losses within 365 days after the date of the accident. The loss must result directly from the injury and from no other causes.

LOSS

BENEFIT

Loss of Life	Principal Sum
Loss of One Member (Hand, Foot or Eye)	1/2 Principal Sum
Loss of Two or More Members	Principal Sum
Loss of Thumb and Index Finger	1/4 Principal Sum
Loss of Both Speech and Hearing in Both Ears	Principal Sum
Loss of Either Speech or Hearing in Both Ears	1/2 Principal Sum
Loss of Hearing in One Ear	1/4 Principal Sum
Quadriplegia (Paralysis of Both Arms and Both Legs)	Principal Sum
Paraplegia (Paralysis of Both Legs)	1/2 Principal Sum
Hemiplegia (Paralysis of Arm and Leg of Same Side)	1/2 Principal Sum

The Principal Sum for the Insured Person's class is shown in the Schedule of Insurance. Under a Family Plan, the Principal Sum which applies to each Dependent is also shown. The Principal Sum for a Dependent is based upon family make-up at the time of the loss.

MAXIMUM PER PERSON. If an Insured Person or Dependent sustains more than one loss resulting from the same accident, the benefit:

- (1) will be the one largest amount listed; and
- (2) will not exceed the Principal Sum for all of that person's losses combined.

TO WHOM PAYABLE. Benefits for the Insured Person's loss of life will be paid in accord with the Beneficiary section. Under a Family Plan, benefits for a Dependent's loss of life will be payable to the Insured Person. Any other benefits will be paid to the Insured Person.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

DEFINITIONS. "Beneficiary" means the person(s) named on the Insured Person's enrollment form. The Insured Person may change the Beneficiary by filing a written notice of the change with the Company at its Group Insurance Service Office.

"Loss of a Member" includes the following:

- (1) "Loss of Hand or Foot," which means complete severance through or above the wrist or ankle joint. (In South Carolina, "Loss of Hand" can also mean the loss of four whole fingers from one hand.)
- (2) "Loss of an Eye," which means total and irrevocable loss of sight in that eye.

"Loss of Thumb and Index Finger" means severance of the thumb and index finger of the same hand, through or above the joint closest to the wrist. (In California, it can also mean loss by complete severance of at least one whole phalanx of each.)

"Loss of Speech" means total and irrevocable loss of audible communication.

"Loss of Hearing" means permanent and total deafness in that ear. The deafness cannot be corrected to any functional degree by any aid or device.

"Paralysis" means complete and irreversible loss or use of an arm or leg (without severance).

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions section.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT
INSURANCE--CONTINUED**

FELONIOUS ASSAULT BENEFIT. The Company will pay an additional 25% of the Insured Person's Principal Sum, if:

- (1) an Insured Person suffers a loss for which an Accidental Death and Dismemberment benefit is payable;
- (2) the injury or death takes place while the Insured Person is on the business of, or on any premises of, the Group Policyholder or Employer; and
- (3) the injury or death is the direct result of:
 - (a) a robbery, holdup, or attempted robbery or holdup;
 - (b) a kidnapping during a holdup; or
 - (c) a felonious assault.

DEFINITION. "Felonious Assault" means one inflicted by persons other than fellow employees or members of the Insured Person's family or household.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Voluntary Accidental Death and Dismemberment Insurance Exclusions which follow.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
CONTINUED**

MONTHLY COMA BENEFIT. The Company will pay a Monthly Coma Benefit, while the Insured Person or a covered Dependent remains in a continuous coma; provided:

- (1) the coma is caused by an Injury sustained while insured under this Policy;
- (2) the coma begins within 365 days after the date of the accident; and
- (3) the person remains in the coma for at least 31 days in a row.

The coma must result directly from the Injury and from no other causes.

This Monthly Coma Benefit:

- (1) will be payable for each month the person is in a continuous coma; but
- (2) in no event will more than 36 months of benefits be paid.

No Monthly Coma Benefit will be paid after the coma ends; whether by death, recovery, or any other change of condition. If, when the coma ends, benefits are due for a period of less than a month; then payment will be prorated. The daily rate will equal 1/30 of the Monthly Coma Benefit.

AMOUNT. The Monthly Coma Benefit will equal 1% of the difference between:

- (1) the Principal Sum that would be payable for the Insured Person's or Dependent's accidental death; and
- (2) the amount of any benefits paid or payable under this Policy for that person's other Scheduled Losses as a result of the same accident.

In no event will the total benefits payable for all of a person's Scheduled Losses resulting from the same accident exceed the Principal Sum, which would be payable for that person's accidental death.

SUBSEQUENT LOSS. If, the Insured Person or Dependent later suffers another scheduled loss covered by this Policy, due to the same accident that caused the coma; then the benefit paid for the later loss will equal:

- (1) the benefit stated in the Schedule of Insurance; reduced by
- (2) the total amount of benefits paid, including the Monthly Coma Benefits paid, for the same person's Scheduled Losses as a result of that accident.

If the person continues to qualify for a Monthly Coma Benefit after the other loss; then the amount of the Monthly Coma Benefit will be redetermined, as shown above.

PROOF. The Insured Person or Beneficiary is responsible for providing the Company proof of the continuing coma. The Company retains the right to investigate, to determine whether the coma exists and continues.

TO WHOM PAYABLE. The Monthly Coma Benefit for the Insured Person will be paid in accord with the Beneficiary section. If the Insured Person is insured under the Family Plan, the Monthly Coma Benefit for a covered Dependent will be paid to the Insured Person.

"Coma" means being in a state of complete mental unresponsiveness, with no evidence of appropriate responses to stimulation.

"Scheduled Loss" means any of the following losses, if covered under this Policy: loss of life, member(s), speech or hearing, paralysis, permanent total disability, coma or common disaster. It does not include any additional seat belt, felonious assault, child care, education, spouse training, spouse critical period, monthly survivors or monthly in-hospital benefits which may be included under this Policy.

EXCLUSIONS. Benefits will not be paid:

- (1) when the person remains in a coma for less than 31 days in a row; or
- (2) for any loss excluded under the Voluntary Accidental Death and Dismemberment Exclusions section.

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)
INSURANCE--CONTINUED**

EXCLUSIONS. No benefit will be paid for loss resulting from:

- (1) intentionally self-inflicted injury or attempted injury, while sane or insane;
- (2) war or any act of war (whether declared or undeclared);
- (3) any accident occurring while the Insured Person or covered Dependent is serving on full-time active duty in the armed forces of any state or country (except for duty of 30 days or less for training in the Reserves or National Guard);
- (4) travel or flight in (or boarding or leaving) any aircraft or device which can fly above the earth's surface, if:
 - (a) the aircraft or device is being used for tests, experimental purposes, or travel beyond the earth's atmosphere (or is designed for such travel);
 - (b) the aircraft or device is being used by or for any military authority (except for aircraft flown by the U.S. Military Aircraft Command or similar service of any country);
 - (c) the aircraft or device is other than a chartered aircraft; and it is being used by or for the Group Policyholder, Employer or its subsidiary or affiliate (whether it is owned, leased, operated or controlled as defined below);
 - (d) the Insured Person or covered Dependent is serving as a pilot, crew member or student taking a flying lesson (and is not riding as a passenger); or
 - (e) the Insured Person or covered Dependent is hang-gliding or parachuting (except where he or she must make a parachute jump for self-preservation);
- (5) the Insured Person's or covered Dependent's commission of a felony;
- (6) sickness, disease or bodily infirmity; except for:
 - (a) a bacterial infection resulting from an accidental cut or wound; or
 - (b) the accidental ingestion of a poisonous food substance; or
- (7) the Insured Person's or covered Dependent's driving a motor vehicle while intoxicated, impaired or under the influence of drugs (except for drugs taken as prescribed by a licensed physician).

DEFINITIONS. As used in this section, "Owned Aircraft" means one the Group Policyholder or Employer holds legal or equitable title to; and can use, alter or sell as desired.

"Leased Aircraft" means one the Group Policyholder or Employer does not own, but can use as desired for the term of a written lease. The time will be longer than a few days or one or two trips. The aircraft cannot be altered or sold without the owner's consent.

"Operated or Controlled Aircraft" means one the Group Policyholder or Employer does not own; but has leased, rented or borrowed and can use as desired for more than 10 straight days. It cannot be altered or sold without the owner's consent.

"Chartered Aircraft" means one the Group Policyholder or Employer does not own; but has hired for one purpose, one trip or general use. The time may not exceed 10 straight days or 15 days in any one year. One or more aircraft hired on a regular or frequent basis are not chartered.

"Intoxicated", "Impaired", or "Under the Influence of Drugs" shall be as defined by the jurisdiction where the accident occurs. The exclusion will apply whether or not the driver is convicted.

SAFE DRIVER BENEFIT

BENEFIT. If an Insured Person dies as a direct result of a covered auto accident, for which Accidental Death and Dismemberment Benefits are payable; then:

- (1) an additional Seat Belt Benefit will be payable, if the Insured Person was wearing a properly fastened seat belt at the time of the accident; and
- (2) an additional Air Bag Benefit will be payable, if the auto was equipped with air bag(s).

The Seat Belt Benefit equals \$10,000 or 10% of the Principal Sum, whichever is less; and the Air Bag Benefit equals \$10,000 or 10% of the Principal Sum, whichever is less. The Seat Belt Benefit and the Air Bag Benefit will not be less than \$1,000. The Principal Sum is the amount payable because of the Insured Person's accidental death.

A copy of the police report must be submitted with the claim. The position of the seat belt or presence of an air bag must be certified by:

- (1) the official accident report; or
- (2) the coroner, traffic officer or other investigating officer.

Upon receipt of satisfactory written proof, the additional benefit will be paid in accord with the Beneficiary section.

DEFINITIONS. As used in this provision:

"Auto" means a 4-wheel passenger car, station wagon, jeep, pick-up truck or van-type car. It must be licensed for use on public highways. It includes a car owned or leased by the Group Policyholder.

"Intoxicated," "Impaired," or "Under the Influence of Drugs" shall be defined as by the jurisdiction where the accident occurs.

"Seat Belt" means a properly installed:

- (1) seat belt or lap and shoulder restraint; or
- (2) other restraint approved by the National Highway Traffic Safety Administration.

LIMITATIONS. Safe Driver Benefits will not be paid if:

- (1) the Accidental Death and Dismemberment Benefits is not paid under this Policy for the Insured Person's death; or
- (2) at the time of the accident, the Insured Person or any other person who was driving the auto in which the Insured Person was traveling:
 - (a) was driving without a valid drivers' license;
 - (b) was driving in excess of the legal speed limit; or
 - (c) was driving while intoxicated, impaired, or under the influence of drugs (except for drugs taken as prescribed by a Physician for the driver's use).

The above limitations will apply, whether or not the driver is convicted.

**CLAIMS PROCEDURES
FOR LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS**

NOTE: This Policy may include an Extension of Death Benefit, an Accelerated Death Benefit or a Living Benefit. If so, please refer to that section for special claim procedures.

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of an accidental death or dismemberment claim must be given within 20 days after the loss occurs; or as soon as reasonably possible after that.* The notice should be sent by first class mail to the Company's Group Insurance Service Office. It should include:

- (1) the Insured Person's name and address; and
- (2) the number of this Policy.

Notice sent to any of the Company's authorized agents in Utah, with enough detail to identify this Policy, will also be deemed notice to the Company.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then the Insured Person or Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of the loss; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. In addition to the information requested on the claim form, documentation must include:

- (1) A certified copy of the death certificate, for proof of death.
- (2) A copy of any police report, for proof of accidental death or dismemberment.
- (3) A signed authorization for the Company to obtain more information.
- (4) Any other items the Company may reasonably require in support of the claim.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if:

- (1) the Insured Person or Beneficiary shows that it was sent as soon as reasonably possible; or
- (2) the Company fails to show that its position was prejudiced by the delay.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have the Insured Person examined:

- (1) by a Physician of the Company's choice;
- (2) as often as reasonably required.

If the Insured Person fails to cooperate with an examiner or fails to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under this Policy will be paid within 15 days after the Company:

- (1) receives complete proof of claim; and
- (2) completes any further claim investigation it needs to confirm liability.

Any claim payment that is not made by the 15th day will accrue interest, at the rate of 10% per year.

TO WHOM PAYABLE

Death. Any benefits payable for the Insured Person's death will be paid in accord with the Beneficiary, Facility of Payment, and Settlement Options sections of this Policy. If this Policy includes Dependent Life Insurance; then any benefits payable for an insured Dependent's death will be paid to:

- (1) the Insured Person, if he or she survives that Dependent; or
- (2) the Insured Person's Beneficiary, or in accord with the Facility of Payment section; if the Insured Person does not survive that Dependent.

CLAIMS PROCEDURES (Continued)

Dismemberment. If this Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than the Insured Person's death benefit, will be paid to the Insured Person.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of this Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after receiving complete proof of claim and completing any further claim investigation needed to resolve the claim. If reasonably possible, the Company will send it within:

- (1) 90 days after receiving the first proof of a death or dismemberment claim; or
- (2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit available under this Policy.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will begin its claim investigation by requesting any additional information needed from others, and will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances requiring the delay, including:

- (1) what additional information is needed;
- (2) whether any part of the claim is contested; and
- (3) when a decision can be expected.

In any event, the Company must send written notice of its decision within:

- (1) 180 days after receiving the first proof of a death or dismemberment claim; or
- (2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit available under this Policy.

If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:

- (1) 60 days after receiving a denial notice of a death or dismemberment claim; or
- (2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit available under this Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The Company will begin any further claim investigation needed, and will send the claimant:

- (1) a written acknowledgement, within 15 days after receiving the appeal; and
- (2) a written delay notice every 30 days after that, until the appeal is decided.

The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision, within 15 days after completing any further claim investigation and deciding the appeal. The notice will explain the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

- (1) any further appeal procedures available under this Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

CLAIMS PROCEDURES (Continued)

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit available under this Policy, the notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the Insured Person a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If accidental death or dismemberment benefits have been overpaid on any claim; then full reimbursement to the Company is required. It must be made within 60 days after the Company sends written notice of the overpayment. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from the Insured Person, or from his or her Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason. This provision will not apply to life insurance benefits.

If benefits have been underpaid on any claim, full payment will be made within 15 days after the Company:

- (1) discovers the error; or
- (2) receives acceptable proof of the additional liability.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S AUTHORITY TO ADMINISTER ERISA PLAN. Benefits under this Policy will be paid only if the Company decides in its discretion that the claimant is entitled to them. The Company also has discretion to determine eligibility for benefits and to interpret the terms and conditions of this Policy. Determinations made by the Company pursuant to this reservation of discretion do not prohibit or prevent the claimant from seeking judicial review in federal court of the Company's determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when the claimant seeks judicial review of the Company's determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to this Policy.

The Company is an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord the Company's determinations.

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE:

- * You must be a Utah resident.
- * You must have insurance coverage under an individual or group policy.

POLICIES COVERED. ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS. Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- * Coverage through an HMO.
- * Coverage by insurance companies not licensed in Utah.
- * Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- * Policies protected by another state's guaranty association.
- * Policies where the insurance company does not guarantee the benefits.
- * Policies where the policyholder bears the risk under the policy.
- * Re-insurance contracts.
- * Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- * Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- * Policies issued to entities that are not members of ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE. Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 -- whichever is lower. Other caps also apply:

- * \$200,000 in net cash surrender values.
- * \$500,000 in life insurance death benefits (including cash surrender values).
- * \$500,000 in health insurance benefits.
- * \$200,000 in annuity benefits -- if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- * \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply.)
- * Interest rates on some policies may be adjusted downward.

DISCLAIMER

(PLEASE READ CAREFULLY)

*** COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

*** COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

*** THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

*** INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

*** THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84020

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

