Group Life
Insurance Voluntary Certificate

University of Richmond
IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of Delaware and will be governed by its laws. If you reside in a state other than Delaware, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Texas residents:

IMPORTANT NOTICE: To obtain information or make a complaint:

You may call Special Marketing Division's toll-free telephone number for information or to make a complaint at 1-800-441-1832.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:
P O Box 149091
Austin, TX  78714-9104
FAX # (512) 475-1771

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

AVISO IMPORTANTE: Para solicitar información o presentar una queja:

Llame a la línea gratuita de la División Especial de Marketing para obtener información o presentar una queja al 1-800-441-1832.

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al 1-800-252-3439.

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas):
P O Box 149091
Austin, TX  78714-9104
FAX: (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.
NOTICE

Benefits paid under the Accelerated Benefits provision will reduce the Death Benefit payable for life insurance.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Employee or the Employee's beneficiary may incur a tax obligation. As with all tax matters, an Employee should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

TL-004788
FOREWORD

Life insurance provides individuals and their families with financial protection. The Life Insurance Benefit described in this booklet will help secure your family's financial security in the event of your death.

The following pages describe the main provisions of the life insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.
We, the LIFE INSURANCE COMPANY OF NORTH AMERICA, have issued a Group Policy, FLX-960295, to TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE SERVICES INDUSTRY on behalf of University of Richmond.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

Karen S. Rohan, President
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SCHEDULE OF BENEFITS

Policy Effective Date: March 1, 2004
Certificate Effective Date: January 1, 2008
Policy Anniversary Date: January 1
Policy Number: FLX-960295

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active Full time Employees of the Employer regularly scheduled to work at least 1,511 hours annually.

Your Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

If you were hired on or before the Policy Effective Date:
   No Waiting Period

If you were hired after the Policy Effective Date:
   No Waiting Period

LIFE INSURANCE BENEFITS

If an Insured is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the date of the change in class.

Employee Benefits

Voluntary Benefit: An amount elected in units of $10,000
   Guaranteed Issue Amount: the lesser of 2 times Annual Compensation or $200,000
   Maximum Benefit: the lesser of 5 times Annual Compensation or $500,000

Age Based Reductions
   If you are age 65 or older, your Life Insurance Benefits are payable as follows:
   Age 65 to 69  65% of Life Insurance Benefits
   Age 70 to 74  45% of Life Insurance Benefits
   Age 75 to 79  30% of Life Insurance Benefits
   Age 80 and Over 20% of Life Insurance Benefits

Terminal Illness Benefit
   Maximum Benefit: $250,000
Increases and Decreases in Coverage

You may increase your Voluntary Term Life Insurance Benefit, at any time, only if you satisfy the Insurability Requirement. Any amount we approve is effective on the date we agree in writing to insure you.

An Employee may reduce Insurance Benefits at any time. The reduced amount will be effective on the date we receive the completed change form.

Re-solicitation Period

During a Re-solicitation Period, or within 31 days after a Life Status Change, if you are currently insured under the Voluntary Life Insurance portion of this Policy, you may increase your Life Insurance Benefits, and if you are eligible for the Voluntary Life Insurance portion of this Policy but have not previously enrolled, you may become insured under the Policy, by satisfying the Insurability Requirement. Your insurance will be effective on the date we agree in writing to insure you.

You may reduce Insurance Benefits at any time. A request for a Benefit reduction received during a Re-solicitation Period will become effective on the Policy Anniversary following the Re-solicitation Period. Any other Benefit reduction will be effective on the date we receive the completed change form.

Spouse or Domestic Partner Benefits

Voluntary Benefit
Guaranteed Issue Amount: $30,000
Maximum Benefit: $50,000

Terminal Illness Benefit
Maximum Benefit: 50% of the Maximum Benefit applicable to your Life Insurance Benefits.

Dependent Child Benefits

Voluntary Benefit
Maximum Benefit: $10,000

The Maximum Benefit for a Dependent Child who is less than 6 months old is $500.

All Dependent Child benefits are Guaranteed Issue.

Former Employee Benefits

Amount of Life Insurance
An amount elected subject to the Maximum Benefit amount for Voluntary Life Insurance Benefits allowable to you, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance.

Maximum Benefit Period
To Age 70.

Terminal Illness Benefit
Maximum Benefit: $250,000
**Spouse or Domestic Partner of Former Employee Benefits**

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WHO IS ELIGIBLE

Classes of Eligible Persons
A person may be insured only once under the Basic Life portion of the Policy even though he or she may be eligible under more than one class. A person may also be insured only once under the Voluntary Life portion of the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

Employee
If you qualify under the Class Definition shown in the Schedule of Benefits, you are eligible to be insured under the Policy on the Policy Effective Date, or the day after you complete the applicable Eligibility Waiting Period, if later.

If you have previously converted your insurance under the Policy, you will not become eligible until your converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of insurance available to you.

Except as noted in the Reinstatement Provision, if you terminate coverage and later wish to reapply, or if you are a former Employee who is rehired, a new Eligibility Waiting Period must be satisfied. You are not required to satisfy a new Eligibility Waiting Period, if insurance ends because you are no longer in a Class of Eligible Employees, but continue to be employed by the Employer, and within one year you become a member of an eligible class.

Spouse
Your Spouse is eligible to be insured on the date you are eligible or the date he or she becomes your Spouse, if later. You must be insured in order to elect spouse coverage.

For eligibility purposes, your Spouse must be a lawful Spouse and not legally separated from, divorced from, or widowed by you. He or she must be under age 70 to be eligible.

Dependent Child
Your Dependent Child is eligible to be insured on the date you are eligible or the date the child becomes a Dependent Child, if later.

In no event will a Dependent Child be eligible to be insured more than once under the Policy.

WHEN COVERAGE BEGINS

You, your Spouse and Dependent Children will be insured for an amount not to exceed the Guaranteed Issue Amount on the date you become eligible, if you are not required to contribute to the cost of this insurance.

You and your Spouse will be insured for an amount that exceeds the Guaranteed Issue Amount on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.
If you elect coverage within 31 days after you become eligible to enroll or increase coverage, the Guaranteed Issue Amount will be effective on the latest of the following dates:
1. The Policy Effective Date.
2. The date you authorize payroll deduction for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

If you or your Spouse elect insurance in an amount that exceeds the Guaranteed Issue Amount or if your enrollment form is received more than 31 days after you become eligible to elect coverage, this insurance is effective on the date we agree in writing to provide this coverage. We will require an eligible person to satisfy the Insurability Requirement before we agree to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date he or she qualifies as a Dependent Child.

If you, your Spouse or Dependent Children are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you, your Spouse or Dependent Children return to Active Service.

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:
1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you, your Spouse or Dependent Children are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for an Employee, Spouse or Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date your coverage ends, for any insured Spouse or Dependent Child.

WHEN COVERAGE CONTINUES

Continuation for Temporary Leave of Absence or Family Medical Leave
If you are an Employee and your Active Service ends due to an Employer approved leave of absence, sabbatical or family medical leave, your insurance will continue for up to the Maximum Benefit Period shown in the Schedule of Benefits, if the required premium is paid.

If your Active Service ends due to a sabbatical or leave of absence approved by the Subscriber or Subscriber’s Board of Trustees or for (1) full-time study or advanced degree; or (2) work in the field of education or research such as Fulbright Award, foundation grant, or governmental project, benefits continue for up to the end of 24 months if the required premium is paid.

If your Active Service ends due to a leave of absence approved in writing by the Employer prior to the date you cease work insurance will continue for you for up to 12 months if the required premium is paid. An approved leave of absence does not include layoff or termination of employment.

If your Active Service ends due to family medical leave approved timely by the Employer, insurance will continue for you for up to 6 months, if the required premium is paid when due.
Waiver of Premium
If you are an Employee under age 60 and your Active Service ends due to Disability, Life Insurance Benefits will continue for you, your Spouse and Dependent Children, if any until the earliest of the following dates.
1. The date you are no longer Disabled.
2. The day after the end of the period for which required premiums are paid.
3. The date you no longer qualify for Waiver of Premium.
4. To Age 65.
If you die while premiums are waived, we will pay a Death Benefit only if due proof of continuous Disability is received within one year of your death.

In order to qualify for Waiver of Premium, you must submit due proof that you have been Disabled for 9 months. Such proof must be submitted to us no later than 12 months from the date your Active Service ends. Premiums will be waived from the date the Insurance Company agrees in writing to waive your premiums. After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled and submit due proof that your Disability continues. Satisfactory proof must be submitted to us 3 months before the end of the 12 month period.

The Death Benefit will be equal to the Life Insurance Benefit in effect on the date you became Disabled. However, this benefit will be subject to the provisions of the Policy that reduce or terminate coverage because of age, retirement, acceleration or a change in eligible class. Automatic increases in Life Insurance Benefits will end while premiums are waived.

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled.
2. The date you refuse to submit to any physical examination required by us.
3. The last day of the 12 month period of Disability during which you fail to submit satisfactory proof of your continued Disability.
4. To Age 65.

Portability Options
For Employees
If your employment ends prior to age 70, you may continue Voluntary Life Insurance Benefits. Benefits will continue in an amount elected, subject to the Maximum Benefit allowable for Voluntary Life Insurance Benefits in effect on the date you no longer qualify as an Employee. Any amount elected in excess of the Voluntary Life Insurance Benefits in effect on the date you no longer qualify as an Employee will be effective on the date we agree in writing to insure you. To continue coverage, you must submit an application to us and pay the required premium. If you continue coverage, you may also continue coverage for your Spouse or Dependent Child in the amount in force on the date coverage would otherwise end. If you do not elect to continue insurance within 31 days after your employment ends, you may not elect this coverage at a later date.

If you continue coverage in this manner you will become a Former Employee. A Spouse whose coverage is continued will become a Spouse of a Former Employee. Coverage will be effective on the first of the month following the date your coverage as an Employee ends, provided we receive your completed application and the required premium is paid.
If, as a Former Employee, you later acquire a Spouse or Dependent Child, you may elect coverage for them by submitting an application to us and paying the required premium. Coverage for your Spouse or Dependent Child will be effective on the date we agree in writing to insure them, if it is not in effect on the date your coverage as an Employee ends. We may require your Spouse or Dependent Child to satisfy the Insurability Requirement before we agree to insure him or her.

Coverage continued in this manner will end on the earliest of the following dates.
1. The date we cancel coverage for all members of your class.
2. The day after the end of the period for which required premiums are paid.
3. The date the Insured is age 70.

Also, coverage for any Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Spouses

If a Spouse is legally separated or divorced from, or widowed by, an insured Employee or Former Employee prior to age 70, he or she may continue Life Insurance Benefits. Benefits will continue in an amount elected, subject to the Maximum Benefit allowable for Life Insurance Benefits. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as a Spouse will be effective on the date we agree in writing to insure him or her. To continue coverage, the Spouse must submit an application to us and pay the required premium.

If a Spouse continues coverage, he or she may also continue coverage for a Dependent Child covered under the Policy on the date coverage would otherwise end. If a Spouse does not elect to continue insurance within 31 days after coverage ends, he or she may not elect this coverage at a later date.

A Spouse who continues coverage in this manner will become a Former Spouse and will be issued a separate certificate of insurance. Coverage will be effective on the first of the month following the date his or her coverage as a Spouse ends, provided we receive the completed application and the required premium is paid.

Coverage continued in this manner will end on the earliest of the following dates.
1. The date we cancel coverage for all members of the Insured's class.
2. The day after the end of the period for which premiums are paid.
3. The date the Insured is age 70.

In addition, coverage for a Dependent Child will end on any of the dates listed above or when he or she no longer qualifies as a Dependent Child, if earlier.

For Dependent Children

If a Dependent Child is insured under the Policy and is at least 23 years of age, he or she may continue Life Insurance Benefits by electing an amount of insurance in units of $25,000 up to a maximum benefit of $50,000. To continue coverage, the Dependent Child must submit an application to us and pay the required premium.

If a Dependent Child does not elect to continue insurance within 31 days after reaching age 23 or the date he or she no longer qualifies as a Dependent Child, if later, he or she may not elect to be insured under this option at a later date.
A Dependent Child who continues coverage in this manner will become a Former Dependent Child and will be issued a separate certificate of insurance. Coverage will be effective on the following dates.

1. For any Guaranteed Issue Amount, the first of the month following the date the Dependent Child's coverage ends, provided we receive the completed application and required premium.
2. For any amount of insurance that exceeds the Guaranteed Issue Amount, the date we agree in writing to insure him or her. We will require the Former Dependent Child to satisfy the Insurability Requirement before we agree to insure him or her.

Coverage continued in this manner will end on the earliest of the following dates.

1. The date we cancel coverage for all members of the Insured's class.
2. The day after the end of the period for which premiums are paid.
3. The date the Insured is age 70.

**WHAT IS COVERED**

**LIFE INSURANCE BENEFITS**

**Death Benefit**
If an Insured dies, we will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

**Seatbelt Benefit**
We will pay 10% of your Basic Life Insurance Benefits in force on the date of an Accident or $10,000, if less, if you die as a result of an Accident and the following conditions are met.

1. The Accident occurs while you are covered as an Employee under the Policy.
2. You are driving or riding as a passenger in a Private Passenger Car, the car is equipped with seatbelts and the seatbelt was in actual use and properly fastened at the time of the Accident. The use and position of the seatbelt must be certified in the official report of the Accident. However, if an official report is not available or it is unclear if you were properly wearing a seatbelt, we will pay $1,000. If such report indicates that a seatbelt was not in use, we will not pay any benefits under this provision.

The Seatbelt Benefit will not be paid for an Accident which occurs while you are participating in a race, speed or endurance test.

"Private Passenger Car" means a validly registered four-wheel vehicle limited to private passenger cars, station wagons, jeeps, pick-up trucks and van-type cars.

**Accelerated Benefits**
Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.
**Terminal Illness Benefit**

We will pay a Terminal Illness Benefit if we determine you or your Spouse are Terminally Ill. The amount of this benefit is 50% of the combined Basic and Voluntary Life Insurance Benefit in effect for you or your Spouse on the date we determine you are Terminally Ill up to the Maximum Benefit Amount shown in your Schedule of Benefits for this option. The Terminal Illness Benefit is payable only once in an Insured's lifetime.

**Determination of Terminal Illness**

For the purpose of determining the existence of a Terminal Illness, we will require you to submit the following proof.

1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to us, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, you to be examined and a review of the documented evidence by a Physician of our choice.

"Terminal Illness" means a person is diagnosed by a Physician to have a prognosis of 12 months or less to live.

**Conversion Privilege for Life Insurance**

If coverage ends for any reason except non-payment of premium, any Insured may apply for a conversion policy of life insurance.

The conversion insurance may be a type of life insurance currently being offered for conversion by us at your age and in the amount requested. It may not be term insurance and it may not be for an amount greater than the Life Insurance Benefits in force under the Policy. Conversion life insurance will not provide accident, disability or other benefits.

However, if coverage ends because the Policy is terminated or amended to terminate any class of Insureds, or the Employer cancels participation under the Policy, coverage cannot be converted unless you have been insured under the Policy for at least 3 years. In this case, the amount of conversion insurance will be the lesser of Life Insurance Benefit in force under the Policy or $10,000.

To apply for conversion insurance, you must submit an application to us and pay the required premium within 31 days after coverage under the Policy ends. Evidence of insurability is not required. Premium for the conversion insurance will be based on your age and class of risk and the type and amount of coverage issued.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends, if your application is received by us and the required premium is paid on that date.

If you die during the 31 day conversion period, the Death Benefit will be paid under the Policy regardless of whether you applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that type and amount of insurance under the Policy.
Extension of Conversion Period

If you are eligible for conversion insurance and are not notified of this right at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. You will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to you by your Employer or mailed to your last known address as reported by your Employer.

If you die during the extended conversion period, but more than 31 days after your coverage under the Policy terminates, Life Insurance Benefits will not be paid under the Policy. If your application for conversion insurance is received by us and the required premium is paid, Life Insurance Benefits will be payable under the conversion insurance.

Prior Conversion Limitation

If you are covered under a life insurance conversion policy previously issued by us under the Policy, you will not be eligible to exercise this Conversion Privilege unless the prior coverage has ended. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance Benefits based on age or a change in class.

LIFE INSURANCE EXCLUSIONS

If an Insured commits suicide, while sane or insane, within 2 years from the date the Insured's insurance under the Policy becomes effective, Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on the Insured's behalf. The suicide exclusion applies from the effective date of any additional benefits or increases in Life Insurance Benefits.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under your certificate, no refund of premiums will be paid.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Written notice, or any other electronic/telephonic means authorized by us, of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice, or any other electronic/telephonic means authorized by us, was given as soon as reasonably possible.
Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof, or any other electronic/telephonic means authorized by us, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.
All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

**Change of Beneficiary**
You may change your beneficiary at any time by giving written notice to the Employer or to us. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or us. When this form is received, it will take effect as of the date of the form. If you die before the form is received, we will not be liable for any payment that was made before receipt of the form.

**Physical Examination and Autopsy**
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

**Legal Actions**
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

**Time Limitations**
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

**Physician/Patient Relationship**
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.
ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If an Insured's coverage amount is reduced due to acceleration of a Death Benefit, premium will be based on the amount of coverage in force on the day before the reduction took place. If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
Your coverage may be reinstated if your insurance ends because you are on an Employer approved unpaid leave of absence. Your insurance may be reinstated only if reinstatement occurs within 12 weeks from the date it ends due to an Employer approved unpaid leave of absence or you must be returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For Sabbatical
Your coverage may be reinstated if your insurance ends because you are on an Employer approved sabbatical. Your insurance may be reinstated only if reinstatement occurs within 24 months from the date the Employer approved sabbatical begins.

For your insurance to be reinstated the following conditions must be met.
1. You must qualify under the Class Definition.
2. The required premium must be paid.
3. A written request for reinstatement and a new enrollment form for you must be received by us within 31 days from the date you return to Active Service.

Your reinstated insurance is effective on the date you return to Active Service. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation (if any) before your insurance ended due to an unpaid leave of absence, you will receive credit for any time that was satisfied.

GENERAL PROVISIONS

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.
**Workers' Compensation Insurance**
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

**Assignment of Benefits**
We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

**Clerical Error**
A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.
DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident
The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

Active Service
If you are an Employee, you are in Active Service on a day which is one of your Employer's scheduled work days if either of the following conditions are met.
1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

A person other than an Employee is considered in Active Service if he or she is able to perform all the activities another person of the same age and sex could normally perform and is not any of the following:
1. A patient in a hospital or hospice, or receiving outpatient care for chemotherapy or radiation therapy.
2. Confined at home under the care of a Physician for sickness or injury.
3. Unable to perform any of the Activities of Daily Living expected of a person of the same age without human supervision or assistance. The Activities of Daily Living are defined as follows:
   a) Mobility - moving from one place to another by means of walking, with or without equipment, or using a wheelchair.
   b) Dressing - putting on and taking off all necessary items of clothing including braces and artificial limbs if they are usually worn.
   c) Toileting - cleansing self after elimination and adjusting clothing before and after using the toilet.
   d) Transferring - moving in or out of a bed, chair or other seat, with or without equipment.
   e) Feeding - getting food into the body, by any means, after it has been prepared and made available to the person.
4. Receiving disability benefits from any source due to his or her sickness or injury.

Annual Compensation
Annual Compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.
**Dependent Child**
Your unmarried child if he or she meets the following requirements:
1. A child 14 days of age but less than 23 years old;
2. A child who is 23 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year. Coverage continues until the end of the calendar year in which the dependent turns age 23.

The term "child" means a child born to or legally adopted by you. It includes a child during any waiting period prior to the finalization of the child's adoption. It also means a stepchild living with and financially dependent upon you.

**Disabled**
You are Disabled, if, because of Injury or Sickness, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

**Employee**
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

**Employer**
The Employer who has subscribed to the Policyholder and for the benefit of whose Employees this policy has been issued. The Employer, named as the Subscriber on the front of this Policy, includes any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

**Full-time**
Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

**Injury**
Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

**Insurability Requirement**
An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

**Insurance Company**
The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

**Insured**
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.
**Physician**
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

**Prior Plan**
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date.

**Sickness**
The term Sickness means a physical or mental illness.

**Spouse**
Your current lawful spouse under age 70.
Rider to Certificate Made a Part of Group Policy No. FLX-960295
Effective Date of Rider: March 1, 2004, or if later the Effective Date of the Employee’s Certificate

MODIFICATION OF GROUP POLICY
TO ADD DOMESTIC PARTNER AS AN ELIGIBLE DEPENDENT
UNDER THE GROUP POLICY FOR TERM LIFE INSURANCE

The provisions of your Certificate are modified as follows:

1. All references to the term "Spouse" are replaced by "Spouse or Domestic Partner", except for the following references:
   a. The definition of "Spouse" remains unchanged.
   b. Any reference to "lawful spouse" or "legal spouse" remains unchanged.
   c. Any reference to "Spouse" remains unchanged in the paragraph entitled "To Whom Payable" under the Claims Provisions.
   d. Any reference to "Spouse" in the "Life Status Change" definition remains unchanged.

2. The following Domestic Partner definition is added to the Definitions section of your Certificate.

   **Domestic Partner** means: a person who meets all of the following criteria:

   a. shares your permanent residence.
   b. has resided with you for at least one year and is expected to continue to reside with you indefinitely.
   c. is financially interdependent with you in each of the following ways:
      i. by holding one or more credit or bank accounts, including a checking account, as joint owners.
      ii. by owning or leasing your permanent residence as joint tenants.
      iii. by naming or being named by you as a beneficiary of life insurance or under a will.
      iv. by each agreeing in writing to assume financial responsibility for the welfare of the other.
   d. has signed a domestic partner declaration with you, if you reside in a jurisdiction that provides for domestic partner declarations.
   e. has not signed a domestic partner declaration with any other person within the last 12 months.
   f. is no less than 18 years of age nor more than 70 years of age.
   g. is legally prohibited from marrying the Employee
   h. is not currently legally married to any other person.
   i. is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress, or fraud.

Your Domestic Partner is eligible for Life Insurance Benefits under the Policy on the later of your eligibility date or the date the person becomes your Domestic Partner and if all the following conditions are met.

   a. You have not been married to any person within the last 12 months.
   b. The Domestic Partner is the only person meeting the Policy’s definition of "Domestic Partner" with respect to you.
c. You and the Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Insurance Company if the requirements cease to be met, on a form acceptable to the Insurance Company.

To obtain insurance for a Domestic Partner, you must request coverage in writing and agree to make any required premium contributions. Insurance will be effective on the same date specified for a Spouse in the When Coverage Begins Provision. The Insurance Company reserves the right to require evidence of good health.

The amount of insurance that applies to a Domestic Partner is shown in the Schedule of Benefits.

If a Domestic Partner is insured under the Policy and then ceases to be your eligible Domestic Partner prior to age 70, he or she may continue Life Insurance Benefits under the Portability Option of the Policy as a Former Domestic Partner. Coverage may be continued for up to the Maximum Benefit shown in the Schedule of Benefits. The Portability Option pertaining to Spouse (except for the first sentence) also pertains to a Domestic Partner.

Death benefits with respect to any Domestic Partner will be payable to the beneficiary chosen by the Domestic Partner. If no beneficiary is named, benefits are payable to you.

Except for the above, this Rider does not change the Certificate to which it is attached.
SUPPLEMENTAL INFORMATION for
University of Richmond
required by the Employee Retirement Income Security Act of 1974

As a Plan participant in University of Richmond's Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

• The Plan is established and maintained by University of Richmond, the Plan Sponsor.

• The Employer Identification Number (EIN) is 54-0505965.

• The Plan Number is 505.

• The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLX-960295, issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.

• The Plan Administrator is: University of Richmond
28 Westhampton Way
Richmond, VA  23173

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

• The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)

• The agent for service of legal process is the Plan Administrator.

• The Plan of benefits is financed by the Employer.

• The date of the end of the Plan Year is December 31.
WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician’s name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company’s written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

YOUR RIGHTS AS SET FORTH BY ERISA

As a participant in University of Richmond's Insurance Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.
IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

California Residents:

Conversion Privilege for Life Insurance
Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.

b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.

C. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.

d. The person meets all other conditions for converting the insurance.

Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee’s Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

Missouri residents:

Suicide while insane is no defense to payment under the accidental death provisions of the Policy unless the Insurance Company can show that the Insured intended suicide when he or she applied for the insurance, regardless of any language to the contrary in the Policy. Suicide while sane is a defense.

Regardless of any language to the contrary in the Policy, suicide is no defense to payment of life insurance benefits. However, if an Insured commits suicide within 2 years from the date his or her insurance under the Policy becomes effective, and the Insurance Company can show that the Insured intended suicide at the time he or she applied for the insurance, life insurance benefits will be limited to a refund of premium paid on the Insured's behalf.

North Dakota residents:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.
Texas residents:

The coverage amount for an Employee under all Employer-sponsored group life programs is limited to seven (7) times his or her salary, or $250,000, whichever is greater. If the Employee’s Spouse and/or Dependent Children are eligible for coverage, their coverage amounts are subject to the same limit.