YOUR BENEFIT PLAN

THE HERTZ CORPORATION

Basic Term Life, Supplemental Dependent Life, Supplemental Term Life

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Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at www.thehartford.com. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233
https://www.thehartford.com/

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
   Arkansas Insurance Department
   1 Commerce Way, Suite 102
   Little Rock, AR 72202

California:

1. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

   Eligibility Determination: *How will We determine Your or Your Dependent's eligibility for benefits?*

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;
2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial.**

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

2. **For Your Questions and Complaints:**
State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.
2. The **Dependent Child(ren)** definition will always include children related to You by civil union.
3. The **Spouse** definition will always include civil unions.
4. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status.**
5. The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

2. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. Lasalle Street, 13th Floor, Chicago, Illinois 60603; and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

   This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:
   Illinois Department of Insurance
   320 W. Washington Street
   Springfield, Illinois 62767-0001

   Illinois Department of Insurance
   115 S. LaSalle Street
   13th Floor
   Chicago, Illinois 60603

   Consumer Complaints: DOI.Complaints@illinois.gov; toll-free: 1(866) 445-5364
   Officer of Consumer Health Insurance: DOI.Complaints@illinois.gov; toll-free: 1(877) 527-9431

2. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at http://insurance.illinois.gov/.

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Louisiana:

1. The age limit stated in the **Continuation for Dependent Child(ren)** with Disabilities provision is increased to 21,

if less than 21.

2. The following requirement applies to you:

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?* If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

   The reinstated coverage will:
   1) be the same coverage amounts in force on the date coverage ended;
   2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
   3) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Massachusetts:

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**

   This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

   If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Michigan:

1. The **Policy Interpretation** provision**,** if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions.**
2. If there are 25 or more residents of Minnesota who are covered under The Policy, or there are fewer than 25 residents and those residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

   Minnesota Coverage Continuation: If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:
   1) the date Your coverage would otherwise terminate; or
   2) the date You receive a written notice of Your right to continue coverage from the Employer;

   whichever is later.

   The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:
   1) Your right to continue coverage;
   2) the amount of premium; and

3) how, where and by when payment must be made.

Upon request, the Employer will provide You Our written verification of the cost of coverage.

Coverage will be continued until the earliest of:

1) the date You are covered under another group policy;
2) the date the required premium is due but not paid; or
3) the last day of the 18th month following the date of termination or Lay Off.

Upon the termination of continued coverage, You may:

1) exercise Your Conversion Right; or
2) continue coverage under a group Portability policy; and
3) qualify for Retiree coverage.

Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.

3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

   In the event:

   1) You are required by law to accelerate benefits to meet the claims of creditors; or
   2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

   You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit
4. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right.**

Missouri:

1. The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180 days.
2. If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.
3. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Montana:

1. The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.
2. If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.
3. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

New Hampshire:

1. Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

   Spouse Continuation: *Can coverage for my Spouse be continued in the event of divorce or separation?*
   If:

   1) You are a resident of New Hampshire;
   2) You get a divorce or legal separation from a Spouse that is covered under The Policy; and
   3) the final decree of divorce or legal separation does not expressly prohibit it;

   Your former Spouse may continue his or her coverage.

   We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

   Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:

1) the 3-year anniversary of the final decree of divorce or legal separation;
2) the remarriage of the former Spouse;
3) Your death;
4) an earlier time as provided by the final decree of divorce or legal separation; or
5) a date the coverage would otherwise have ended under the Dependent Termination Provision.

New Mexico:

1. **For Your Questions and Complaints:**
   Office of Superintendent of Insurance
   Consumer Assistance Bureau
   P.O. Box 1689
   Santa Fe, NM 87504-1689
   1(855) 427-5674

New York:

1. If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you: The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
   1) you are both legally and mentally competent to consent to contract in the state in which you reside;
   2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
   3) you have been living together on a continuous basis prior to the date of the application;
   4) neither of you have been registered as a member of another domestic partnership within the last six months; and
   5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

   The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:
   1) a joint bank account;
   2) a joint credit card or charge card;
   3) joint obligation on a loan;
   4) status as an authorized signatory on the partner's bank account, credit card or charge card;
   5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
   6) listing of both partners as tenants on the lease of the shared residence;
   7) shared rental payments of residence (need not be shared 50/50)
   8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
   9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
   10) shared household budget for purposes of receiving government benefits;
   11) status of one as representative payee for the other's government benefits;
   12) joint responsibility for child care (e.g., school documents, guardianship);
   13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
   14) execution of wills naming each other as executor and/or beneficiary;
   15) designation as beneficiary under the other's life insurance policy;
   16) designation as beneficiary under the other's retirement benefits account;
   17) mutual grant of durable power of attorney;
   18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
   19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
   20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
   1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
   2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

North Dakota:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Ohio:

1. Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

Oregon:

1. The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to $2,000, if greater than $2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.
3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your

Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.

4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate**,** is not applicable.
2. **NOTICE:**

Have a complaint or need help?

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

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

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford
Email: GBD.Customerservice@hartfordlife.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: GBD.Customerservice@hartfordlife.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3. When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after **Proof of Loss** is received.
4. Any reference to fraud within the **Incontestability** provision does not apply to You.
5. A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions.**

Vermont:

1. The following requirement applies:

   Purpose: This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

   General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

   1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
   2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
   3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
   4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.
   5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

   Cautionary Disclosure: THIS NOTICE IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE NOTICE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS NOTICE. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT

2. Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate

of 6% annually or Our corporate interest rate, whichever is greater.

Virginia:

1. **For Your Questions and Complaints:**
   State Corporation Commission
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   1(804) 371-9691 (inside Virginia)
   1(877) 310-6560 (outside Virginia)

Washington:

1. The following **Disputed Diagnosis** requirement applies to You:

   Disputed Diagnosis: *What happens if a dispute occurs over whether I am Terminally Ill or my Dependent is Terminally Ill?*
   If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other, or may divide the costs equally or otherwise.

2. A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.
3. The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.
4. The definition of **Spouse** will always include domestic partners.
5. The provision titled **Suicide** does not apply to you.

Wisconsin:

1. **For Your Questions and Complaints:**
   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza

Hartford, Connecticut 06155

1-800-523-2233

The toll free telephone number is for Policyholders and Employees to present inquiries or obtain information about coverage and to provide assistance in resolving complaints.

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

CERTIFICATE OF INSURANCE

Policyholder: THE HERTZ CORPORATION
Policy Number: GL-803546
Policy Effective Date: July 1, 2019
Policy Anniversary Date: January 1

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, *Secretary*

Michael J. Fish, ***Head of Group Benefits***

A note on capitalization in this Certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of: February 1, 2026

Cost of coverage:
Non-Contributory Coverage: Basic Life Insurance

Contributory Coverage: Supplemental Life Insurance
Supplemental Dependent Life Insurance

Disclosure of Fees:
We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Disclosure of Payment to the Policyholder:
We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:
1) audit;
2) marketing communication services; and
3) other administrative expenses.

Eligible Class(es) For Coverage: All Full-time and Part-time Active Employees including employees who are subject to a collective bargaining agreement located in Hawaii who participate in the Hertz Custom Benefit Program who are citizens or legal residents of the United States, its territories and protectorates; excluding leased or seasonal employees.

Full-time Employment: at least 30 hours weekly
Part-time Employment: at least 20 hours weekly

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:
1) The first day of the month coinciding with or next following 28 day(s) of employment - if You are working for the Employer on the Policy Effective Date; or
2) The first day of the month coinciding with or next following 30 day(s) of employment - if You start working for the Employer after the Policy Effective Date.

The time period(s) referenced above is continuous.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer under the Prior Policy.

Life Insurance Benefit

Basic Amount of Life Insurance:

Maximum Amount

1 times Your annual Earnings, subject to a maximum of $1,500,000 rounded to the nearest $1,000 if not already a multiple of $1,000.

However, in no event will Your Basic Amount of Life Insurance be less than $10,000 before any reductions in coverage due to age apply.

Supplemental Amount of Life Insurance

Guaranteed Issue Amount	**Maximum Amount**

5 times Your annual Earnings, subject to a maximum of $300,000 rounded to the nearest $1,000 if not already a multiple of $1,000.	1, 2, 3, 4, 5 or 6 times Your annual Earnings, subject to a maximum of $3,000,000 rounded to the nearest $1,000 if not already a multiple of $1,000.

However, in no event will Your Supplemental Amount of Life Insurance be less than $10,000 before any reductions in coverage due to age apply.

Dependent Life Insurance Benefit

Supplemental Amount of Dependent Life Insurance

	Guaranteed Issue Amount	Maximum Amount
Spouse	$50,000	Option 1: $10,000 Option 2: $20,000 Option 3: $30,000 Option 4: $40,000 Option 5: $50,000 Option 6: $100,000
Dependent Children: live birth but under age 26 year(s)		The amount You elect in increments of $5,000, subject to a minimum of $5,000 and a maximum of $15,000.

The amount of Spouse Supplemental coverage may never exceed 100% of the Supplemental Amount of Life Insurance in force for the Employee.

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

1) in accordance with the Conversion Right;
2) under the Portability Provision; or
3) under the Prior Policy.

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit for You and Your Spouse by the percentage indicated in the table below. This reduction will be effective on the date You attain the ages shown below. The reduction will apply to the Amount of Life Insurance in force immediately prior to the first reduction made.

These reductions also apply if:

1) You or Your Spouse become covered under The Policy; or
2) Your or Your Spouse's coverage increases;

on or after the date You attain age 65.

Percentage by which original amount of coverage will be reduced.

Your Age	Your % Reduction	Your Spouse's % Reduction
65	35%	35%
70	60%	60%
75	75%	75%

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:
1) the Policy Effective Date;
2) the date You become a member of an Eligible Class; or
3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:
1) the date You become insured for employee coverage; or
2) the date You acquire Your first Dependent.

You may not elect coverage for Your Dependent if such Dependent is covered as an Active Employee under The Policy. No person can be insured as a Dependent of more than one employee under The Policy.

Enrollment: *How do I enroll for coverage?*
For Non-Contributory Coverage, Your Employer will automatically enroll You. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us, for Your and Your Dependent's coverage; and
2) deliver it to Your Employer.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 60 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll for Your coverage and/or Your Dependent's coverage only:
1) during an Annual Enrollment Period designated by the Policyholder; or
2) within 60 days of the date You have a Change in Family Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability for initial coverage, if You:
1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:
1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Dependent Evidence of Insurability Requirements: *When will my Dependents first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You enroll for an Amount of Dependent Life Insurance greater than the Supplemental Dependent Guaranteed Issue Amount, regardless of when You enroll.

However, no Evidence of Insurability will be required if the Amount of Life Insurance for Your Dependent Child(ren) is $15,000 or less.

If Your Dependents' Evidence of Insurability is not satisfactory to Us:

1) Your Dependents' Amount of Life Insurance will equal the amount for which Your Dependents were eligible without providing Evidence of Insurability, provided You enrolled Your Dependents within 60 days of the date You were first eligible to enroll;
2) Your Dependents will not be covered under The Policy if You enrolled Your Dependents more than 60 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:
1) a completed and signed application approved by Us;
2) an attending Physician's statement; and
3) any additional information We may require.

Evidence of Insurability will be furnished at Our expense for Evidence of Insurability due to late enrollment. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:
1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:
1) the date You become eligible, if You enroll on or before that date;
2) the July 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 60 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were:
1) insured under the Prior Policy; and
2) Actively at Work;

but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:

1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date: *When does Dependent coverage start?*
Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the July 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 60 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible for Dependent coverage; or
2) the date We approve Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become insured.

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent, other than a newborn, is to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit; and

he or she is:

1) confined in a hospital; or
2) Confined Elsewhere

such coverage will not start until he or she:

1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Child(ren).

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependents?*
If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

1) Your Dependents had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or

2) that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage: *When may I change my coverage or coverage for my Dependents?*
After Your initial enrollment You may increase or decrease coverage for You or Your Dependents or add a new Dependent to Your existing Dependent coverage:

1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date of a Change in Family Status.

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

1) the date of the change;
2) the date requirements of the Deferred Effective Date provision are met;
3) the date Evidence of Insurability is approved, if required; or
4) the July 1st on or next following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

With respect to Supplemental Life:
Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself, must I provide Evidence of Insurability?*
If You are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must provide Evidence of Insurability for an increase of more than one level; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, You must provide Evidence of Insurability for any amount of Supplemental Life Insurance coverage including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

With respect to Supplemental Dependent Life:
Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for my Dependents, must we provide Evidence of Insurability?*
If Your Dependents are:

1) already enrolled for an Amount of Supplemental Dependent Life Insurance under The Policy, then Your Dependents must provide Evidence of Insurability for an increase over $50,000; or
2) not already enrolled for an Amount of Supplemental Dependent Life Insurance under The Policy, Your Dependents must provide Evidence of Insurability for an amount greater than $50,000 including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, Your Dependents must provide Evidence of Insurability.

If Your Dependents' Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance he or she had in effect on the date immediately prior to the date You requested the increase will not change.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
3) the date the premium payment is due but not paid;
4) the date Your Employer terminates Your employment; or
5) the date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:

1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Employer terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent,

unless continued in accordance with the Continuation Provisions.

Continuation Provisions: *Can my coverage and my Dependent's coverage be continued beyond the date it would otherwise terminate?*
Coverage under The Policy may be continued, at Your Employer's option, beyond a date shown in the Termination provision, provided Your Employer provides a plan of continuation which applies to all employees the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:
1) is subject to any reductions in The Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively.

In no event will coverage under the following Continuation Provisions, when combined, extend longer than 12 months from the date You were last Actively at Work: Leave of Absence, Military Leave of Absence, Sickness or Injury or Family Medical Leave.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for 24 months after the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You or Your Dependent enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 24 months. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:
1) for a period of 24 consecutive months from the date You were last Actively at Work; or
2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 24 consecutive months.

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Continuation for Dependent Child(ren) with Disabilities: *Will coverage for Dependent Child(ren) with Disabilities be continued?*
If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:
1) age 26 or older; and
2) disabled; and
3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:
1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Child(ren) will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

BENEFITS

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*
If You or Your Dependents die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Suicide: *What benefit is payable if death is a result of suicide?*
If You or Your Dependent commit suicide while sane or insane, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in Earnings.

This 2 year period includes the time group life insurance coverage was in force under the Prior Policy.

Any premium paid by You during this 2 year period for initial amounts of Supplemental Life Insurance or elected increases in Supplemental Life Insurance, will be returned to Your beneficiary.

Accelerated Benefit: *What is the benefit?*
In the event that You or Your Dependent are diagnosed as Terminally Ill, while the Terminally Ill person is:

1) covered under The Policy for an Amount of Life Insurance of at least $10,000; and
2) under age 60;

We will pay the Accelerated Benefit in a lump sum amount as shown below, provided We receive proof of such Terminal Illness.

The Accelerated Benefit will not be available to You unless You have been Actively at Work under The Policy.

You must request in writing that a portion of the Terminally Ill person's Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. Any premium required will be based on the amount of Your life insurance remaining after the Accelerated Benefit is paid under this benefit.

You may request a minimum Accelerated Benefit amount of $3,000 and a maximum of $500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of the Terminally Ill person's Amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from $10,000 to $80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $30,000 now, You cannot request the additional $50,000 in the future.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your or Your Dependent's Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Amount of Life Insurance as used in this benefit means Basic and Supplemental Life Insurance.

Terminal Illness or Terminally Ill means a life expectancy of 24 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependents do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependents refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy reduces or terminates for any reason shown in the Termination provision, except nonpayment of premium, You and Your Dependents may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for any Amount of Life Insurance for which You or Your Dependents were eligible and not covered under The Policy.

If coverage under The Policy terminates because The Policy is terminated then You or Your Dependent must have been insured under The Policy or Prior Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

1) $10,000; or
2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy terminates because coverage for an Eligible Class is terminated then You or Your Dependent must have been insured under The Policy, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy terminates for any other reason shown in the Termination provision, except nonpayment of premium, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage or my Dependents' coverage?*
To convert Your coverage or coverage for Your Dependents, You must:

1) apply in writing to Us; and
2) submit the required premium with the application.

Your application and first premium payment must be received by Us within 31 days after Life Insurance terminates. Requests for Conversion may still be accepted by Us if received beyond 31 days if:

1) You were not given written notice of your right to convert within 15 days of Your Life Insurance terminating; and
2) it is received by Us no later than 20 days after You were given notice of Your right to convert.

However, even if You were notified late, We will not accept Your application if it is received more than 91 days after Life Insurance terminates.

If conversion is applied for more than 31 days after Life Insurance terminates, the person who is applying for conversion must be living at that time. We will not accept a conversion application on behalf of a deceased person more than 31 days after Life Insurance terminates.

Any individual policy issued to You or Your Dependents under the Conversion Right:

1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions: *What are the Conversion Policy provisions?*
The Conversion Policy will:

1) be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

1) the same terms and conditions of coverage as The Policy;
2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which is being continued:

1) under a certificate of insurance issued in accordance with the Portability provision; or
2) in accordance with the Continuation Provisions;

until such coverage ends.

Death within the Conversion Period: *What if I or my Dependents die before coverage is converted?*
We will pay the deceased person's Amount of Life Insurance You would have had the right to apply for under this provision if:

1) coverage under The Policy terminates; and
2) You or Your Dependent die within 31 days of the date coverage terminates; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Portability Benefits: *What is Portability?*
Portability is a provision which allows You and Your Dependents to continue coverage under a group Portability policy when coverage would otherwise end due to certain Qualifying Events. Portability applies to Basic and Supplemental Life Insurance only.

Qualifying Events: *What are Qualifying Events?*
Qualifying Events for You are:

1) Your employment terminates prior to Normal Retirement Age; or
2) You are denied Waiver of Premium solely because You do not meet the definition of Disabled;

provided the Qualifying Event occurs prior to Normal Retirement Age.

Qualifying Events for Your Dependents are:

1) Your employment terminates prior to Normal Retirement Age;
2) Your death;
3) Your membership in a class eligible for Dependents' coverage ends due to the exhaustion of Your Leave of Absence, Military Leave of Absence or Family Medical Leave; or
4) he or she no longer meets the definition of Dependent, however, a Dependent Child(ren) who reaches the limiting age under The Policy is not eligible for Portability;

provided the Qualifying Event occurs prior to Normal Retirement Age.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to Your own Qualifying Event.

Electing Portability: *How do I elect Portability?*
You may elect Portability for Your coverage after Your Life Insurance coverage ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available. Portability will not be available to You or Your Dependents unless You have been Actively at Work under The Policy.

To elect Portability for You or Your Dependents, You must:

1) apply in writing; and

2) submit the required premium with the application.

You have the option to elect Portability by voice recording or electronically.

Your application and first premium payment must be received by Us or postmarked within 31 days after Life Insurance terminates. Requests for Portability may still be accepted by Us if received or postmarked beyond 31 days if:

1) You were not given notice of your right to port within 15 days of Your Life Insurance terminating; and
2) it is received by Us or postmarked no later than 20 days after You were given notice of Your right to port.

However, even if You were notified late, We will not accept your application if it is received or postmarked more than 91 days after Life Insurance terminates.

If Portability is applied for or the application is postmarked more than 31 days after Life Insurance terminates, the person who is applying for portability must be living at that time. We will not accept a portability application on behalf of a deceased person more than 31 days after Life Insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

1) issued on one of the forms then being issued by Us for Portability purposes; and
2) effective on the day following the date Your or Your Dependent's coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Evidence of Insurability may be required for amounts elected over the Portability Guaranteed Issue Amount of $250,000 for You and $50,000 for Your Spouse. If Evidence of Insurability is not satisfactory to Us, the coverage under the Portability policy will be limited to amounts under the Portability Guaranteed Issue Amount. However, You may be able to convert Your remaining coverage as described in the Conversion Right provision under The Policy.

Limitations: *What limitations apply to this benefit?*

You may elect to continue up to 50%, 75% or 100% of the Amount of Life Insurance which is ending for You or Your Dependents. This amount will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. However, the Amount of Life Insurance that may be continued will not exceed:

1) $1,000,000 for You;
2) $50,000 for Your Spouse; or
3) $10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75%, or 100% now, You may not increase the elected amount at a later date.

Portability is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered.

In addition Portability is not available if You or Your Dependents are entering active military service.

Effect of Portability on Other Provisions: *How does Portability affect other Provisions?*

Portability is not available for any Amount of Life Insurance which was, or is being, continued in accordance with the:

1) Conversion Right; or
2) Continuation provisions;

under The Policy. However, if:

1) You elect to continue only a portion of terminated coverage under this Portability Benefit; or
2) the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

You, or the person who has the right to claim benefits, must give Us written notice of a claim within 30 days after the date of death. If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*

We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your Enrollment form;
4) Your Beneficiary Designation (if applicable);
5) documentation of:
    a) the date Your disability began;
    b) the cause of Your disability; and
    c) the prognosis of Your disability; or
6) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us within 365 days after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as reasonably possible; but
3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Benefits may be subject to interest payments as required by applicable law.

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1) the executors or administrators of Your estate;
2) all to Your surviving spouse;
3) if Your spouse does not survive You, in equal shares to Your surviving children;
4) if no child survives You, in equal shares to Your surviving parents; or
5) if no parent survives You, in equal shares to Your surviving siblings.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

1) $200 at Your death; and
2) monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit at Your Dependents' death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving spouse or the executor or administrator of Your estate.

If benefits are payable and meet Our guidelines, then You, or Your beneficiary, may elect to receive benefits in a lump sum payment or may elect to receive benefits through a draft book account. The draft book account will be owned by:

1) You, if living; or
2) Your beneficiary, in the event of Your death.

However, an account will not be established for:

1) a benefit payable to Your estate; or
2) an amount that is less than $10,000.

In these circumstances, We will pay benefits in a lump sum payment.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent,

then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Beneficiary Designation: *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Policy Interpretation: *Who interprets the terms and conditions of the Policy?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability: *When can the Life Insurance Benefit of The Policy be contested?*
Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

No statement made by You or Your Spouse relating to Your or Your Spouse's insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You and Your Spouse.

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You or Your representative.

All statements made by the Policyholder, the Employer or You or Your Spouse under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

Assignment: *Are there any rights of assignment?*
You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions: *When can legal action be taken against us?*
Legal action cannot be taken against Us:

1) sooner than 180 days after the date written Proof of Loss is furnished; or
2) more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Insurance Fraud: *How does the Company deal with fraud?*
Insurance fraud occurs when You, Your Dependents and/or the Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents and/or the Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your Dependents and/or the Employer perpetrate insurance fraud.

Misstatements: *What happens if facts are misstated?*
If material facts about You or Your Dependents were not stated accurately:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

1) in the usual way; and
2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day, paid time off day, personal day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:
Your children, stepchildren, legally adopted children, or any other children related to You by blood or marriage or domestic partnership provided such children are:

1) from live birth but not yet 26 years; or
2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

Any child who is in active full-time military service cannot be a Dependent Child.

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States of America, Puerto Rico, Guam and any other locations where We may legally provide such coverage.

Earnings means Your regular annual rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day You were Actively at Work.

However, if You are an hourly paid Active Employee, Earnings means the product of:

1) the average number of hours You worked per year, not including overtime, over the most recent 1 year period immediately prior to the last day You were Actively at Work, multiplied by:
2) Your hourly wage in effect on the date immediately prior to the last day You were Actively at Work.

Employer means the Policyholder.

Guaranteed Issue Amount means the Amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Normal Retirement Age means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Physician means a person who is:

1) a doctor of medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Prior Policy means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Related means Your Spouse, or someone in a similar relationship in law to You, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Spouse means Your spouse who:

1) is not divorced from You; and
2) is not in active full-time military service.

Spouse will include Your domestic partner provided You:

1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
2) have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this Certificate of Insurance is issued.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   For employees of THE HERTZ CORPORATION:

   Group Basic Term Life Plan

   Group Supplemental Dependent Life Plan

   Group Supplemental Term Life Plan

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2. **Plan Number**

   Group Life - 505

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3. **Employer/Plan Sponsor**

   THE HERTZ CORPORATION
   8501 WILLIAMS ROAD
   ESTERO, FL 33928

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4. **Employer Identification Number**

   13-1938568

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5. **Type of Plan**

   Welfare Benefit Plan providing:

   Group Basic Term Life Insurance

   Group Supplemental Dependent Life Insurance

   Group Supplemental Term Life Insurance

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6. **Plan Administrator**

   THE HERTZ CORPORATION
   8501 WILLIAMS ROAD
   ESTERO, FL 33928

7. **Agent for Service of Legal Process**

For the Plan

THE HERTZ CORPORATION
8501 WILLIAMS ROAD
ESTERO, FL 33928

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions**

(Group Life) Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) 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 Benefits Security Administration.
b) 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.
c) 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.

2. 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.

3. 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 the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

4. 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 Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits 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 Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.