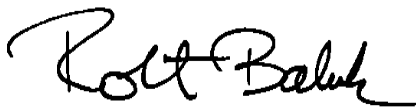
GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois, 60025

This Policy is issued to the Policyholder by Guarantee Trust Life Insurance Company (herein referred to as We, Us, Our) on the Policy Effective Date at 12:01 a.m. standard time at Policyholder's address. The Policyholder and Policy Effective Date are shown on the Schedule of Benefits.

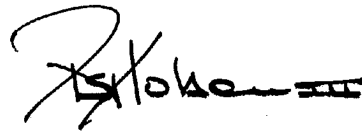
This Policy is governed by the laws of the State where it is issued and is a legal contract between Us and Policyholder.

We hereby insure Eligible Persons of the Policyholder for whom premium has been timely paid. Eligible Persons are defined on the Schedule of Benefits. We agree to pay benefits set forth in the Policy. Benefit payment is governed by the terms of this Policy.

READ YOUR POLICY CAREFULLY.



Secretary



President

ONE YEAR NON-RENEWABLE TERM

BLANKET ACCIDENT POLICY

NON-PARTICIPATING

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

TABLE OF CONTENTS

	Page
Definitions	3
Conditions of Insurance	
Eligibility	9
Effective Date	9
Termination	9
Scope of Coverage	10
Accidental Death, Dismemberment, and Loss of Sight, Speech or Hearing Benefit	10
Accident Medical Expense Benefits	11
Exclusions	12
Premium	
Payment of Premium	13
Due Date	13
Change to Premium	13
Grace Period	13
Claim Provisions	
Notice of Claim	13
Claim Forms	13
Proof of Loss	13
Time of Payment of Claims	13
Payment of Claims	14
Physical Examination and Autopsy	14
Legal Actions	14
Subrogation	14
General Provisions	
Entire Contract; Changes	15
Incontestability	15
Insurance Class	15
Clerical Error	15
Information and Records	15
Non-Participating	15
Conformity with State Statutes	15
Certificate of Insurance	15
Schedule of Benefits	16

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

DEFINITIONS

Accident: A sudden, unforeseeable, external event which results in an Injury.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide:
1. transportation to a Hospital; or
2. transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means.

Air ambulance charges are only eligible for transportation from the site of an Emergency to the nearest appropriate facility or from facility to facility.

Ambulatory Surgical Facility: A facility which meets licensing and other legal requirements and which:
1. Is equipped and operated to provide medical care and treatment by a Doctor;
2. Does not provide services or accommodations for overnight stays;
3. Has a medical staff that is supervised full time by a Doctor;
4. Has full-time services of a licensed registered nurse (R.N.) at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has X-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.

Benefit Period: The number of days following the date of an Injury during which Covered Charges must be incurred, subject to the Initial Treatment Period. The Benefit Period begins on the date of Injury and ends on the last day of the Benefit Period. The Benefit Period is shown on the Schedule of Benefits.

Concussion: A traumatic brain injury caused by an external physical force that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities, physical functioning or the disturbance of behavioral or emotional functioning. These impairments may be temporary or permanent and cause partial or functional disability or psychosocial maladjustment. It must:
a. Occur while the Policy is in force;
b. Occur while the Insured is participating in a Covered Activity; and
c. Diagnosed or treated by a Doctor within 5 days of the Injury.

Covered Activity: Any activity which the Policyholder requires the Insured to attend, or any activity of the Policyholder's school which is under the sole control and supervision of the Policyholder, but not including activities which are under the sponsorship or supervision arrangement with any non-Policyholder group.

Covered Charge: The Reasonable and Customary charge for a service or supply listed in this Policy which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury. A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

Covered Person: A person:
1. who is eligible for coverage as an Insured; and
2. who has been accepted for coverage or has been automatically added; and
3. who has paid the required premium; and
4. whose coverage has become effective and has not terminated.

Designated Vehicle: A Motor Vehicle designated by and under the direct supervision of the Policyholder and operated by a properly licensed adult driver which transports Insureds to and from Covered Activities.

Disappearing Deductible: The dollar amount of Covered Charges paid by the Insured before benefits will be paid under the Accident Medical Expense Benefit. The deductible will be reduced by the amount of medical charges paid by Other Valid and Collectible Insurance or Plan for medical charges arising out of the covered Injury that gave rise to the claim under this Benefit.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT
ORIGINAL

Doctor: A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and who is not a Family Member.

Durable Medical Equipment: A device which:

1. is primarily and customarily used for medical purposes; and
2. is specially equipped with features and functions that are generally not required in the absence of Injury; and
3. is used exclusively by the Insured; and
4. is routinely used in a Hospital, but can be used effectively in a non-medical facility; and
5. can be expected to make a meaningful contribution to the Insured's Injury; and
6. is prescribed by a Doctor and the device is Medically Necessary for the Insured's rehabilitation.

Durable Medical Equipment does not include:

1. comfort and convenience items; and
2. equipment that can be used by Family Members other than the Insured; and
3. health exercise equipment; and
4. equipment that may increase the value of the Insured's Residence.
5. modifications to the Insured's residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or
6. corrective shoes; or
7. exercise and sports equipment.

Eligible Person: An Eligible Person, as defined by the Policyholder, is shown on the Schedule.

Emergency: An Injury for which the Insured seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that, without immediate medical care, the Insured could reasonably expect that:

1. his or her life or health would be in serious jeopardy; or
2. his or her bodily functions would be seriously impaired; or
3. a body organ or part would be seriously damaged.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished; or
2. the informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law; or
3. the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval; or
4. reliable evidence shows that the drug, device or medical care or treatment:
    a. is the subject of ongoing Phase I or Phase II clinical trials; or
    b. is the research, experimental study or investigational arm of on-going Phase III clinical trials; or
    c. is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
5. reliable evidence shows that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

Reliable evidence means only:

1. published reports and articles in authoritative medical and scientific literature; or
2. written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or
3. the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment.

Covered Charges will be considered in accordance with the drug, device or medical care at the time the charge is incurred.

Family Member: A person who is related to the Insured in any of the following ways: spouse, domestic or civil union partner (as defined, and as permitted, by law), brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child).

Hospital: An institution licensed, accredited or certified by the State which:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations; and
2. provides 24-hour nursing service by registered nurses (R.N.); and
3. mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
4. maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

The term Hospital also includes tax-supported institutions which are not required to maintain surgical facilities.

The term Hospital does not include a place, special ward, floor or other accommodation used for:

1. custodial or educational care; or
2. rest; or
3. the aged; or
4. a nursing home;

or an institution mainly rendering treatment or services for mental illness or substance abuse.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 18 consecutive hours by reason of an Injury for which benefits are payable.

Initial Treatment Period: The number of days following an Injury during which the Insured must seek initial treatment for an Injury. The Initial Treatment Period is shown on the Schedule of Benefits.

Injury: Bodily injury due to an Accident which:

1. results directly and independently of disease, bodily infirmity, or any other causes; and
2. solely, directly and independently of all other causes, results in medical expense; and
3. occurs after the effective date of the Insured's coverage under this Policy; and
4. occurs while this Policy is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Insured: An Eligible Person who has satisfied all of the following requirements:

1. He or she is eligible for coverage under the Policy.
2. He or she has been accepted for coverage under the Policy, or has been automatically added.
3. Premium has been paid for him or her.
4. His or her coverage has become effective and has not terminated.

Insured Percent: The percentage of Covered Charges We pay for each Injury. The Insured Percent is shown on the Schedule of Benefits.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT
ORIGINAL

Intensive Care Unit: A specifically designed facility of the Hospital that provides the highest level of medical care; and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care Unit does not mean any of these step-down units: progressive care; sub-acute intensive care; intermediate care units; private monitored rooms; observation units; or other facilities which do not meet the standards for Intensive Care.

Interscholastic: a sport or activity organized between schools or representatives of the schools.

Intramural: a sport or activity within a particular institution and describes sports matches, activities, or contests that take place among teams from "within the walls" of an institution or area.

Maximum Benefit Amount: The maximum amount of benefits We will pay for any one Injury under the Accident Medical Expense Benefit. The Maximum Benefit Amount is shown on the Schedule of Benefits.

Medically Necessary: A treatment, drug, device, procedure, supply, or service that is necessary and appropriate for the diagnosis or treatment of an Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply, or service shall not be considered as Medically Necessary if it:

1. is Experimental/Investigational or for research purposes; or
2. is provided solely for education purposes or the convenience of the Insured, the Insured's family, Doctor, Hospital or any other provider; or
3. exceeds, in scope, duration, or intensity, that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care; or
4. could have been omitted without adversely affecting the person's condition or the quality of medical care; or
5. involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
6. involves a service, supply, or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. can be safely provided to the patient on a less cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply, or drug is Medically Necessary.

Mental or Nervous Disorder: Any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to the Insured.

Motor Vehicle: Any registered motorized vehicle or conveyance with four or more wheels which is designated for travel on public roads or property and is not otherwise excluded.

Off-Season Physical Conditioning: School/team sanctioned and supervised off-season workouts and training for covered student athletes.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred available from any other source whatsoever, except gifts and donations, but including without limitation:

1. any individual, group, blanket, or franchise policy of accident, disability or health insurance; or
2. any arrangement of benefits for members of a group, whether insured or uninsured; or

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

3. any prepaid service arrangement such as Blue Cross or Blue Shield, individual or group practice plans, or health maintenance organizations; or
4. any amount payable for Hospital, medical, or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy; or
5. any amount payable for; services or injuries or diseases related to the Insured's job to the extent that he actually received benefits under a Workers' Compensation Law; or the settlement a Covered Person enters into to give up his or her rights to recover future medical expenses that would have been payable except for that settlement; or
6. Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Insured after he or she becomes disabled while insured hereunder; or
7. any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

ORIGINAL

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, manipulation or massage.

Policyholder: The entity to which this Policy is issued.

Policy Year: The period of 12 months following the Policy's Effective Date.

Post Injury Concussion Testing: An assessment to evaluate brain function following a Concussion for the purpose of clinical management of the Concussion. It must be:

a. compared against a prior established baseline test;
b. related to a covered Injury to the head received during participation in a Covered Activity;
c. initially performed within 30 days of the Injury; and
d. recommended by a Doctor.

Pre-existing Condition: A condition for which medical care, treatment, diagnosis or advice was received or recommended within the 12 months prior to the Insured's Effective Date of coverage under this Policy.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for the Insured's outpatient use.

Reasonable and Customary Charges, Fees, or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies, or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

1. the actual amount charged by the provider; or
2. the negotiated rate; or
3. the charge which would have been made by the provider (Doctor, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by Us for the same service or supply.

"Geographic Area" means the three-digit zip code prefix in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug, or supply.

Repetitive Motion Sports Injuries: Temporary or permanent injuries to muscles, nerves, ligaments, and tendons caused by doing the same motion over and over again.

Residence: The home and land or property on which the Insured's dwelling or home is located.

Sound Natural Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

Terrorist Activity: An act or acts of any person or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. It may include, but not be limited to the actual use of force or violence and/or the threat of such use. The perpetrators of Terrorist Activity can either be acting alone or on behalf of, or in connection with any organization(s) or governments.

Urgent Care Center: A healthcare facility, separate and distinct from a Hospital, providing immediate short-term medical care for minor conditions without an appointment but where immediate medical care is necessary.

ORIGINAL

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

CONDITIONS OF INSURANCE

ELIGIBILITY

An Eligible Person, as shown on the Schedule of Benefits, is eligible to be insured on the Policy Effective Date, or the date he or she becomes eligible, if later.

We maintain the right to investigate eligibility status to verify that eligibility requirements are met as defined by the Policyholder. If We discover that eligibility requirements are not met, Our only obligation is to refund any premium paid for that person, less any claims paid.

EFFECTIVE DATE

Policyholder: This Policy shall be effective, subject to the receipt of premium, on the later of:
1. the Effective Date shown on the application; or
2. the date We approve the application.

The Effective Date is shown on the Schedule of Benefits.

Insured: Subject to receipt of premium, coverage is effective on the Effective Date shown on the Schedule of Benefits.

TERMINATION

Policyholder: This Policy is issued for the term stated on the Schedule of Benefits, on the Effective Date of this Policy.

Insured: All Sports Accident Coverage: Coverage will terminate at the earlier of:
1. the date the Policy terminates; or
2. the date the Insured ceases to be a member of the Policyholder's sports teams; or
3. the last day of regularly scheduled sports activity in which the Insured participates; or
4. the date the Insured ceases to be an Eligible Person; or
5. the end of the period for which any applicable premium has been paid.

Insured: Other Accident Coverage: Coverage will terminate at the earlier of:
1. the date the Policy terminates; or
2. the date the Insured ceases to be an Eligible Person; or
3. the end of the period for which any applicable premium has been paid.

Termination of coverage will not affect a claim for a covered loss that occurred while the Insured's coverage was in force.

We have the right to terminate the coverage of any Insured who submits a fraudulent claim under the Policy.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

SCOPE OF COVERAGE

Subject to the Eligibility, Effective Date, and Termination provisions, an Insured will be covered for Accidental Injury that occurs while insured as elected by the Policyholder and, if applicable, as elected on their enrollment form.

All Sports Accident Coverage: If this option is shown on the application all Insureds, including student coaches, student managers and student trainers, will be covered for Injury which is incurred while the Insured is participating in or attending Interscholastic and Intramural athletic activities, which are officially authorized, sanctioned and scheduled by the Policyholder, supervised by a coach, referee, or by another adult specifically assigned supervisory duties and authority and governed by the rules and regulations of the appropriate athletic/activities association or organization. This includes related:

1. pre-competition activities; and
2. regularly-scheduled practice or training sessions; and
3. a scheduled tryout, workout session or team meeting; and
4. regularly-scheduled competition or exhibition game; and
5. Off Season Physical Conditioning; and
6. sponsored team travel authorized, organized, and supervised by the Policyholder.

Coverage is also provided while traveling directly and uninterruptedly to or from the location designated by the Policyholder for athletic activities in a Designated Vehicle.

Other Accident Coverage: If this option is shown on the application all Insureds will be covered for Injury which is incurred while participating in a Covered Activity as described in Scope of Coverage on the Schedule of Benefits and Motor Vehicle injuries sustained when:

1. Away from the Policyholder’s premises while participating in or attending any Covered Activity, or traveling to and from such activity in a Designated Vehicle, whether or not such Policyholder is in session.

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If Injury from an Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. Such loss must occur within 365 days of such Accident. If the Insured sustains more than one such loss as the result of one Accident, We will pay only one amount, the largest to which the Insured is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing which cannot be corrected by any means. Loss of a thumb and index finger means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body.

Benefit payment is subject to the definitions, limitations, exclusions and other provisions of this Policy.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT
ORIGINAL

ACCIDENT MEDICAL EXPENSE BENEFITS

Subject to the definitions, limitations, exclusions, and other provisions of the Policy, We will pay benefits, as defined and limited below, for Covered Charges incurred by the Insured due to Injury.

Covered Charges are payable only for an Injury:

1. for which the first treatment or service is incurred within the Initial Treatment Period; and
2. for which the charge for all treatment or services is incurred within the Benefit Period.

Covered Charges are shown on the Schedule of Benefits.

<u>No Other Valid and Collectible Insurance or Plan</u>
We will pay the Insured Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury.

<u>Other Valid and Collectible Insurance or Plan</u>
We will pay the Insured Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Injury.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, Our plan will pay first, if it has been in effect for the longer period of time at the date of such Injury.

For purposes of this Policy, the Insured's entitlement to Other Valid and Collectible Insurance or Plan will be determined as if this Policy did not exist and shall not depend upon whether timely application for benefits from Other Valid and Collectible Insurance or Plan is made by or on behalf of the Insured.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

EXCLUSIONS

This Policy does not provide benefits for:

1. treatment, services, or supplies which:
    a. are not Medically Necessary; or
    b. are not prescribed by a Doctor as necessary to treat an Injury; or
    c. are determined to be Experimental/Investigational in nature; or
    d. are received without charge or legal obligation to pay; or
    e. are received from persons employed or retained by the Policyholder or any Family Member, unless otherwise specified; or
    f. are not specifically listed as Covered Charges in this Policy; or
2. intentionally self-inflicted Injury; or
3. Injury received while violating or attempting to violate any duly enacted law; or
4. Injury by acts of war, whether declared or not; or
5. Injury received while traveling or flying by air, except as a fare-paying passenger on a regularly scheduled commercial airline; or
6. Injury covered by Workers' Compensation or the Occupational Disease Law; or
7. Treatment of Mental or Nervous Disorders not caused by Injury; or
8. Injury caused by or contributed to by aggravation or re-injury of a Pre-existing Condition; or
9. suicide or attempted suicide; or
10. charges incurred for the use of orthotics, unless used exclusively to promote healing; or
11. any penalty imposed by Other Valid and Collectible Insurance or Plan for failure to follow plan procedures; or
12. dental treatment, except as specifically stated; or
13. routine eye exams; or
14. Injury sustained fighting, except as an innocent victim; or
15. Injury sustained as a result of the Covered Person's commission of a felony for which the Covered Person has been convicted; or
16. loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; or
17. loss resulting from the use of any drug or agent classified as narcotic, psycholytic, psychedelic, hallucinogenic, or having a similar classification or effect, unless prescribed by a Doctor; or
18. Injury sustained while operating, riding in or upon, mounting or alighting from, any two- or three- or four-wheeled recreational motor/engine driven vehicle, or snowmobile, or all-terrain vehicle (ATV); or
19. cosmetic or plastic surgery, except for reconstructive surgery on an injured part of the body; or
20. Injury resulting from participation in or practice for any activity which is not supervised and sponsored by the Policyholder or school; or
21. treatment of illness, disease or infections, except infections which result from an accidental Injury or infections which result from accidental, involuntary or unintentional ingestion of a contaminated substance; or
22. charges for treatments, services or supplies which exceed reasonable and customary charges; or
23. losses directly or indirectly arising out of any chemical or biological release and/or contamination which results from Terrorist Activity; or,
24. any loss as the result of Terrorist Activity and/or non-detonating weapons of mass destruction; or
25. any loss directly or indirectly arising out of any nuclear explosion, detonation, release and/or contamination whether in time of peace or war, and regardless of any other causes or events contributing concurrently or in any other sequence thereto.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

PREMIUM

Payment of Premium/Due Date: All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and receipt of the required premium at Our home office, or by Our agent.

Returned or Dishonored Payment: If a check in payment for the Premium is dishonored for insufficient funds, a reasonable service charge may be charged to You which will not exceed the maximum specified under state law. A dishonored check shall be considered a failure to pay Premium and coverage shall not take effect.

Change to Premium: We may change the required premium at any time when any change affecting the rates is made to the Policy. We must give at least 45 days written notice to the Policyholder of a change of 20% or more. Changes may not occur during the initial 12 months that this Policy is inforce and not more than once in any 6-months period following the initial 12 months period except for

- The addition of newly Covered Person's;
- A change in age or geographic location of the Policyholder;
- An increase in the benefits under the policy.

Grace Period: We allow a grace period of 31 days for the payment of premium after the first premium. Coverage is in force during the grace period. If, at least 60 days prior to the premium due date, We send written notice to You of Our intent not to renew this Policy, then the grace period will not apply to any period after the date the non-renewal is to be effective. If You send written notice to Us of Your intent not to renew this coverage, then the grace period will not apply after the date the non-renewal is to be effective.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to Us or Our authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Insured.

Claim Forms: Upon receipt of written notice of claim, We will furnish to the claimant such forms as are usually furnished by Us for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be furnished to Us or Our authorized representative within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible and in no event later than one year from the time proof is otherwise required.

Time of Payment of Claims: All claims will be paid not more than 30 days from the date upon which written notice and proof of claim, in the form required by the terms of the Policy, are furnished to Us or Our authorized representative, unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. We will make payment every 30 days to the Insured during that part of the period of disability covered by the Policy. If We fail to comply with the above, We may be subject to a penalty payable to the Insured of double the amount of the benefits due under the Policy during the period of delay together with attorney fees to be determined by the court.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

Payment of Claims: Benefits payable under this Policy for loss of life will be paid to the Insured's next of kin and the provisions respecting such payment set out herein and effective at the time of payment. Any other payable benefits remaining unpaid at the time of the Insured's death may, at Our option, be paid to the Insured's next of kin or to the Insured's estate. All other benefits will be payable to the Insured or the medical services provider if We have received a valid assignment by the Insured.

If any indemnity of this Policy shall be payable to the estate of the Insured or to an Insured who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity to his parent, guardian or other person actually supporting him. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Subject to any written direction of the Insured or of the legal or natural guardian of the Insured, if the Insured is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by this Policy as a result of medical, surgical, dental, hospital or nursing service may, at the Company option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services; but it is not requested that the services be rendered by a particular Hospital or person.

Physical Examination and Autopsy: At Our own expense, We shall have the right and opportunity to examine the Insured as We may reasonably require while a claim is pending. At Our own expense, We may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Legal Actions: A legal action may not be brought to recover on this Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after three years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for the Insured under the terms of this Policy, We shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured against any person who might be acknowledged as liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to Our recovery of the benefits We have paid for such hospitalization and treatment. Our right of subrogation is secondary to the right of the Insured to be fully compensated for his damages, and We shall pay the fees and costs associated with such recovery.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

GENERAL PROVISIONS

Entire Contract; Changes: This Policy, including the application, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

Our failure to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are, or are not, the same.

Incontestability: All statements made in an application by the Policyholder are, in the absence of fraud, representations and not warranties. No statement shall be used to contest this Policy, the validity of coverage or reduce benefits, unless it is in writing, signed by the Policyholder, and a copy of such statement is furnished to the Policyholder.

Insurance Class: Policyholder may set forth in its application Insurance Classes of Eligible Persons. The Policyholder shall notify Us when a change of Insurance Class occurs for the Insured.

Clerical Error: If a clerical error is made so that an otherwise Eligible Person's coverage does not become effective, coverage may be in effect if:

1. the Policyholder makes a written request for coverage on a form approved by Us; and
2. any premium not paid because of the error is paid in full from the effective date of coverage.

We reserve the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Policyholder shall reimburse Us for the overpayment.

Information and Records: The Policyholder shall provide Us information necessary to administer coverage under the Policy. Information is required when an Eligible Person becomes covered, when changes in amounts of coverage occur, and when the Insured's coverage terminates.

Non-Participating: The Policy is non-participating. It does not share in Our profits or surplus earnings.

Conformity with State Statutes: If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Certificate of Insurance: Where required by law, We will send to the Insured an individual certificate. The certificate will outline the insurance coverage under the Policy and to whom benefits are payable.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT
ORIGINAL

SCHEDULE OF BENEFITS

POLICYHOLDER INFORMATION

Policy Number:	174-0AD-001 G
Policyholder:	Lafayette Parish School Board
Policy Effective Date:	July 1, 2023
Policy Term:	July 1, 2023 to July 1, 2024
Eligible Persons:	Students who are enrolled and attending the Policyholder's School as Full-time students.
Scope of Coverage:	All Sports Accident Coverage. Other Accident Coverage: Extra-curricular Activities (sport and non-sport), ROTC, Band, Cheerleading, Skateboard Club and Majorettes.
	The date premium is received by Us or Our Representative, but not prior to the opening day of School, except in the case of All Sports Accident Coverage, in which case coverage will begin on the first official day of practice.

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The losses listed below are payable per Insured, per Accident, unless specified otherwise in the Policy.

Loss of Life	$20,000
Loss of Both Hands	$20,000
Loss of Both Feet	$20,000
Loss of the Entire Sight of Both Eyes	$20,000
Loss of One Hand or One Foot	$10,000
Loss of One Hand and Entire Sight of One Eye	$20,000
Loss of One Foot and the Entire Sight of One Eye	$20,000
Loss of Speech or Hearing (both ears)	$20,000
Loss of Hearing One Ear or Entire Sight of One Eye	$10,000
Loss of Thumb and Index Finger of the Same Hand	$5,000

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Benefit Amount, Per Injury	$25,000
Disappearing Deductible per Injury	$0
Insured Percent	100%
Payment System Percentile	90th
Initial Treatment Period	90 days
Benefit Period	52 weeks

COVERED CHARGES

Treatment, services, or supplies incurred for:
• Hospital room and board and general nursing care, up to the semi-private room rate.
• Intensive Care.
• Inpatient miscellaneous Hospital charges, limited to a maximum of $1,000.
• Miscellaneous outpatient Hospital charges, limited to a maximum of $1,200.
• Doctor's charges for surgery, limited to a maximum of $1,000.
• Administration of anesthesia.
• Assistant surgeon charge.
• Non-surgical Inpatient Doctors' visits.
• Non-surgical Outpatient Doctors' visits, limited to $60 for the first visit and $40 each visit thereafter.
• Hospital Emergency care, excluding professional charges, limited to a maximum of $1,000.
• Outpatient imaging procedures and interpretation for MRI/CAT scan, limited to a maximum of $500.
• Outpatient X-ray services, limited to a maximum of $300.
• Outpatient laboratory services, limited to a maximum of $300.
• Ambulance charges, limited to a maximum of $300.
• Urgent Care Center charges, limited to a maximum $1,000. Does not include professional surgical charges.
• Hospital Emergency non-surgical Doctor charges.
• Durable Medical Equipment, including orthopedic appliances, limited to a maximum of $140.
• Replacement expense for broken eyeglasses, lenses, contact lenses, hearing aids resulting from an Injury requiring medical treatment, limited to a maximum of $300.
• Ambulatory Surgical Facility, limited to a maximum of $1,200.
• Prescription Drugs, limited to a maximum of $200. It is the responsibility of the Insured to pay any applicable local taxes on the sale of the prescription drugs and pharmacist services.
• Dental treatment for Injury to Sound Natural Teeth, limited to a maximum of $250 per tooth.
• Outpatient Physical Therapy rendered by a Hospital or Doctor, up to a maximum benefit of $420.
• Registered Nurse expense.
• Treatment of heat exhaustion and heat stroke.
• Treatment of a Concussion and Post Injury Concussion Testing.
• Treatment of heart and/or circulatory system resulting from participation in a Covered Activity.
• Treatment of Repetitive Motion Sports Injuries, strains, hernia, tendinitis, bursitis, spondylolysis, osteochondritis dissecans.

TO VERIFY DOCUMENT AUTHENTICITY A WATERMARK OF THE WORD "ORIGINAL" SHOULD APPEAR IN BACKGROUND OF DOCUMENT

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

AMENDMENT RIDER

EFFECTIVE DATE: ______________________________

This Rider is made a part of the Policy/Certificate as of the Effective Date shown above. If no date is shown, it is effective as of the Effective Date of the Policy/Certificate to which this Rider is attached.

The Policy/Certificate is hereby amended as follows:

The following term is ADDED to *DEFINITIONS*:

Heart and Circulatory Malfunction: An acute onset of a myocardial infarction, coronary thrombosis or cerebral vascular accident affecting the heart or circulatory system:

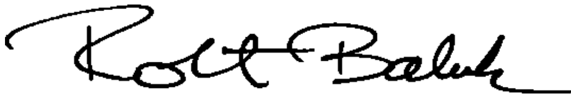
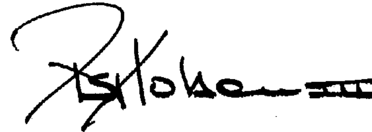
1. which is first diagnosed and treated while the Insured's coverage under this policy is in force;
2. which occurs as a result of the Insured's participation in a Covered Activity;
3. which occurs within 24 hours of participation in a Covered Activity; and
4. which does not result from a Pre-Existing Condition.

The *Treatment of heart and/or circulatory system* section of COVERED CHARGES has been replaced by the following:

- Treatment for Heart and Circulatory Malfunction, resulting from participation in a Covered Activity.

This Rider is subject to all terms, provisions, limitations and exclusions of the Certificate except when specifically changed by this rider.

Signed at Guarantee Trust Life Insurance Company in Glenview, Illinois by

Secretary President

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Box 3337
Baton Rouge, Louisiana 70821

Department of Insurance
P.O. Box 94214
Baton Rouge, Louisiana 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 *et seq.* The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

(over)

EXCLUSIONS FROM COVERAGE

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

(1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
(2) The insurer was not authorized to do business in this state;
(3) His policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

(1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
(2) Any policy of reinsurance (unless an assumption certificate was issued);
(3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;
(4) Dividends, premium refunds, or similar fees or allowances described under the Law;
(5) Credits given in connection with the administration of a policy by a group contract holder;
(6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;
(7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b));
(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;
(9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;
(10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

(1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.
(2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
(3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

GUARANTEE TRUST LIFE INSURANCE COMPANY
PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) we know the importance of the right to privacy. That's why protecting the information that personally identifies each and every one of our valued insurance customers is high priority, and a matter we take very seriously.

Our primary goal is, and will continue to be, providing competitive, fairly priced, and exceptional quality insurance products to meet the short-term and long-term financial needs of our customers. From life and health insurance to credit life and credit disability insurance, getting people the protection they need is not just a job to us. It is a privilege.

While the personal, financial and medical information shared with us (from applying for coverage, to filing a claim) is the cornerstone to providing the high-quality insurance protection and service our customers have come to know and expect, be assured that information, unique to our insurance customers, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with them. Remember, protecting our customer's privacy is not only our priority…it's a promise.

The following is a summary of our privacy policy and practices. It tells you about the kinds of personally identifiable information we collect, disclose or share with others.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION
In order for GTL to provide and administer the insurance products we offer, we collect personal information about the customer. Some of the information we collect is "nonpublic". The nonpublic personal information we collect is obtained from the following sources:

- Information we receive on the application for insurance or other forms *(such as name, address, telephone number, age, social security number, and beneficiary designation.)*

- Information about our customer's transactions with us and our affiliates *(such as the type of insurance product purchased, the premium paid, the method of purchase, and payment history.)*

- Information we receive from third party reports, *(such as consumer-reporting/credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.)*

INFORMATION WE DISCLOSE
GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, except as permitted or required by law.

We may also disclose all of the information we collect, as described above, with the following:

- Affiliates – We may share information with our affiliates. Our affiliates offer products and services that may complement insurance purchases and we believe may be of interest to our customers.

- Service Providers – We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction a customer requests or authorizes; to develop or maintain computer software; or to perform market research.

- Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY
All medical information is kept confidential. We will not use or share, internally or with third-parties, our customer's medical information except for the purposes of:
- Underwriting;
- Administering the policy or claim;
- As permitted or required by law; or
- As authorized by the customer.

SECURITY AND CONFIDENTIALITY OF CUSTOMER INFORMATION
We restrict access to nonpublic personal information about our customers to those employees (or people working on our behalf under confidentiality agreements) who need to know the information in order to provide products and services. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard all nonpublic personal information.

GTL
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

GUARANTEE TRUST LIFE INSURANCE COMPANY

Consent for Use of Electronic Records and Electronic Signatures

PLEASE PRINT AND SAVE A COPY OF THIS DOCUMENT FOR YOUR RECORDS

In connection with your application for, or administration of, insurance underwritten by Guarantee Trust Life Insurance Company ("GTL"), you are consenting to the use of Electronic Signatures and Electronic Records. As part of your consent to the use of Electronic Signatures and Electronic Records you acknowledge that you: (1) understand the terms and conditions of receiving insurance documents, disclosures and other communications electronically; (2) have the necessary hardware and software that allow you to receive and view Electronic Records; (3) have a valid active email account*; and (4) are responsible for accessing, opening, and reading communication GTL sends or makes available to you in electronic format. GTL will consider electronic communication to be received by you upon successful delivery to the designated email address you provide. You also acknowledge that your Electronic Signature is legally binding and enforceable and is the legal equivalent of your handwritten signature.

*An active email address is not required for viewing and / or downloading a copy of your insurance coverage from GTL's secure website.

GTL is required by law to provide you with the following information relative to (i) electronic delivery of disclosures, notices and other electronic communications (collectively, "Electronic Records") and (ii) Electronic Signature.

Types of Electronic Records Covered by This Consent

Unless you request otherwise, documents that form our insurance relationship will be provided to you electronically. Electronic Records include, but are not limited to:

- Application(s) and related forms
- Policy or certificate insurance fulfillment documents
- Disclosures and notices, where required by state and / or federal law
- Customer service forms and claim forms
- Responses to customer service or claim-related communications initiated by GTL or you

Your consent does not apply to policy lapse or termination notices.

What You Need in Order to Receive or View Electronic Records

In order to access and view communications and documents GTL makes available to you electronically, you must:

- Have access to the internet and be able to view, save and print Portable Document Files (PDF) using software such as Adobe Acrobat Reader. Adobe Acrobat Reader can be downloaded for free at http://get.adobe.com/reader/
- Maintain a valid active email address. It is your responsibility to provide GTL with your complete and accurate email address, as well as provide prompt notification of any change to it. To ensure Electronic Records are not blocked in email or spam filters, please add GTL's domain, gtlic.com, to your safe sender list.

<u>Your Right to Request Paper Copies</u>

To ensure you have them when you need them, it's recommended that you print copies of the Electronic Records GTL makes available to you, or save them to your personal computer or other electronic device. However, you may request a paper copy of any Electronic Record listed above free of charge. Except where prohibited by law, GTL may charge a nominal fee for additional copies requested after the first. Your request can be sent in writing, by phone, or email as indicated in the Company Contact Information, shown below.

<u>Right to Send Paper</u>

GTL reserves the right to provide paper copies in lieu of Electronic Records. This would be done in the event of, but not limited to, a system outage, if fraud is suspected, or where the designated email address you have provided does not accept emails from GTL.

<u>Changes to the Terms and Conditions of Electronic Communication</u>

GTL reserves the right to modify the terms and conditions stated herein. GTL will provide you with notice electronically of such change, its effective date, and your choices under the new terms and conditions.

<u>Withdrawal of Consent</u>

You may elect to withdraw your consent for Electronic Records at any time by contacting us in writing, by phone, or through the Policyholder - Customer Service link on GTL's website. Please see the Company Contact Information below.

<u>Company Contact Information</u>

1. Write us at…
   Guarantee Trust Life Insurance Company
   ATTN: Policyholder Service
   1275 Milwaukee Avenue
   Glenview, IL 60025

2. Call us toll-free at…
   1-800-338-7452

3. Contact us by email by visiting our website…
   Go to <u>www.gtlic.com</u>. Click on the *Customer Service* tab at the top of the screen and choose *Customer Support*. In the Customer Support site there is a *Contact Us* option you may use to email us your request.