

YOUR ACCIDENT INSURANCE PLAN

For Employees of
Kivi Bros Trucking, Inc.

GROUP ACCIDENT INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

POLICY EFFECTIVE DATE: July 1, 2022

GOVERNING JURISDICTION: Minnesota

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Covered Accidents as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Covered Accidents as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.**

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address.

The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Exclusions may apply. Please read your Certificate carefully.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

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Arizona Residents -

Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:

If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Florida Residents -

The benefits of the Policy providing Your coverage are governed primarily by the law of a state other than Florida.

Idaho residents:

If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 10 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

New Mexico residents:

If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 30 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

West Virginia residents -

Please read this Certificate carefully. If you are not satisfied with it for any reason, you may return it within 10 days after receipt for a refund of any premium you paid.

SCHEDULE OF BENEFITS

EMPLOYER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

ELIGIBLE CLASS(ES)

All Eligible Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT

20 hours per week.

ELIGIBILITY WAITING PERIOD

Persons in an eligible class on or before the Policy effective date: None

Persons entering an eligible class after the Policy effective date: None

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

ACCIDENT BENEFITS

ACCIDENT HOSPITAL CARE

Surgery - open abdominal, thoracic	\$1,200
Surgery - exploratory or without repair	\$175
Blood, Plasma, Platelets	\$600
Hospital Admission	\$1,250
Hospital Confinement	\$275
Critical Care Unit (CCU) Confinement	\$450
Rehabilitation Facility Confinement	\$200
Coma	\$17,000
Transportation	\$750
Lodging	\$180
Family Care	\$25

ACCIDENT CARE

Initial Doctor Visit	\$90
Urgent Care Facility Treatment	\$225
Emergency Room Treatment	\$225
Ambulance	
Ground	\$360
Air	\$1,500
Follow-Up Doctor Treatment	\$90
Chiropractic Treatment	\$45
Medical Equipment	\$200
Physical or Occupational Therapy	\$45
Speech Therapy	\$45
Prosthetic Device - one	\$750
Prosthetic Device - 2 or more	\$1,200
Major Diagnostic exams	
CT (computerized tomography) or CAT scan (computerized axial tomography)	\$275
MRI (magnetic resonance imaging)	\$275
EEG (electroencephalogram)	\$275
PET (positron emission tomography) scan	\$275
Outpatient Surgery	\$225
X-ray	\$75

COMMON INJURIES

Burns	
2 nd degree - at least 36% of the body	\$1,250
3 rd degree - at least 9 but less than 35 square inches of the body	\$7,500
3 rd degree - 35 or more square inches of the body	\$15,000
Skin Grafts	50% of Burn Benefit
Emergency Dental Work	
Crown	\$350
Extraction	\$90
Eye Injury	
Surgery	\$350
Removal of foreign object	\$100

Torn Knee Cartilage	
Surgery with no repair or if cartilage is shaved	\$225
Surgical repair	\$800
Laceration (total of all lacerations)	
treated, no sutures	\$30
sutures, up to 2 inches	\$60
sutures, 2 to 6 inches	\$240
sutures, over 6 inches	\$480
Ruptured Disk - surgical repair	\$800
Tendon/Ligament/Rotator Cuff	
One, surgical repair	\$825
2 or more, surgical repair	\$1225
Exploratory Arthroscopic Surgery with no repair	\$425
Concussion	\$225
Paralysis	
Quadriplegia	\$24,000
Paraplegia	\$16,000
Dislocations (closed & open reduction)	Closed Reduction /Open Reduction
Hip Joint	\$3,850/\$7,700
Knee	\$2,400/\$4,800
Ankle or Foot Bone(s) other than toes	\$1,500/\$3,000
Shoulder	\$1,600/\$3,200
Elbow	\$1,100/\$2,200
Wrist	\$1,100/\$2,200
Finger/Toe	\$275/\$550
Hand Bone(s) other than fingers	\$1,100/\$2,200
Lower Jaw	\$1,100/\$2,200
Collarbone	\$1,100/\$2,200
Partial Dislocations	25% of Closed Reduction Amount

Fractures (closed & open reduction)	Closed Reduction/ Open Reduction
Hip	\$3,000/\$6,000
Leg	\$2,500/\$5,000
Ankle	\$1,800/\$3,600
Kneecap	\$1,800/\$3,600
Foot (excluding toes, heel)	\$1,800/\$3,600
Upper Arm	\$2,100/\$4,200
Forearm, Hand, Wrist (except fingers)	\$1,800/\$3,600
Finger, Toe	\$240/\$480
Vertebral Body	\$3,360/\$6,720
Vertebral Processes	\$1,440/\$2,880
Pelvis (except Coccyx)	\$3,200/\$6,400
Coccyx	\$400/\$800
Bones of Face (except nose)	\$1,200/\$2,400
Nose	\$600/\$1,200
Upper Jaw	\$1,500/\$3,000
Lower Jaw	\$1,440/\$2,880
Collarbone	\$1,440/\$2,880
Rib or Ribs	\$400/\$800
Skull - simple (except bones of face)	\$1,400/\$2,800
Skull - depressed (except bones of face)	\$3,000/\$6,000
Sternum	\$360/\$720
Shoulder Blade	\$1,800/\$3,600
Chip Fractures	25% of Closed Reduction Amount

ADDITIONAL BENEFIT(S)

Sports Accident Benefit

An additional 25% of the Accident Hospital Care, Accident Care, or Common Injuries benefit amount listed above, up to a maximum benefit of \$1,000.

DEFINITIONS

Accident or **Accidental** means an unforeseen event that results in a bodily Injury.

Active Employment means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:

- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

Certificate means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

Child or **Children** means your unmarried natural or adopted child or stepchild or child for whom you or your Spouse are a legal guardian, from birth to 26 years of age. This includes your grandchild who is financially dependent on you and resides with you continuously from birth.

It also includes a Child of your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

This definition includes your Child age 26 or older who remains dependent on you for support and maintenance because that Child is incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability. Written proof of the Child's incapacity must be furnished along with any proof of claim.

Child Care Center means any facility or private care that:

- is licensed as such by the state,
- provides non-medical care and supervision for Children, and
- is not operated by you or a member of your immediate family.

Chip Fracture means a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Chiropractor means a person other than you or any family member, who is licensed to diagnose and treat neuromuscular disorders, with an emphasis on treatment through manual adjustment and/or manipulation of the spine, in the state in which treatment is received and providing treatment or advice in accordance with the license.

Coma means a state of unconsciousness for 14 consecutive days due to a Covered Accident with:

- no reaction to external stimuli,
- no reaction to internal needs, and
- the use of life support systems.

Confined or **Confinement** means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or Rehabilitation Facility. There must be a charge for room and board.

Covered Accident means an Accident that:

- occurs on or after your coverage effective date and the effective date of any riders,

- occurs while your coverage is in force, and
- is not excluded by name or specific description in the Policy.

Critical Care Unit means a specifically designated part of a Hospital commonly referred to as an intensive care unit which meets all of the following requirements:

- It provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care.
- It is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- It is permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- It is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis.
- It is assigned a Doctor on a full-time basis.

Critical Care Unit does not include a sub-acute intensive care unit that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward such as a step-down unit.

Dislocation means a separated joint.

- **Open Reduction** of Dislocation = surgical reduction of a completely separated joint.
- **Closed Reduction** of Dislocation = non-surgical reduction of a completely separated joint.
- **Incomplete** Dislocation = the joint is not completely separated.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Emergency Room means a specified area within a Hospital, or a standalone facility licensed as an emergency room with the state, that is designated for emergency care.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Eyelid means the moveable fold of skin and muscle that covers the eye.

Fracture means a broken bone that can be seen by x-ray.

- **Open Reduction** of Fracture = surgical.
- **Closed Reduction** of Fracture = non-surgical.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located.
- It is under the supervision of a medical staff and has one or more Doctors available at all times.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial,

educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Injury means a bodily Injury that is the direct result of a Covered Accident and not related to any other cause. Injuries must be independent of Sickness, disease, bodily infirmity and other causes.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Occupational Therapist means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. An occupational therapist provides services designed to restore self-care, work, and leisure skills to patients/clients who have specific performance incapacities or deficits that reduce their abilities to cope with the tasks of everyday living. An occupational therapist evaluates and treats problems arising from developmental deficits, physical illness or injury, emotional disorders, the aging process, and psychological or social disability.

Organized Sporting Activity means a competition or supervised organized practice for a competition. The competition must be governed by a set of written rules, be officiated by someone certified to act in that capacity, and overseen by a legal entity such as a public school system or sports conference. The legal entity must have a set of bylaws and competition must be on a regulation playing surface. Participation must be on an amateur basis.

Outpatient Surgery means surgical services received at a Hospital or free-standing facility such as a surgical center licensed by the state to render Outpatient Surgery. The surgical service must be performed by a board certified surgical specialist with anesthesia rendered by a separate provider.

Paralysis means spinal cord Injuries sustained in a Covered Accident that result in the loss of use of two or more arms and legs.

- **Paraplegia** = the complete and irreversible Paralysis of both legs.
- **Quadriplegia** = the complete and irreversible Paralysis of both arms and both legs.

Physical Therapist means a person other than you or any family member, who:

- is licensed by the state to practice physical therapy
- performs services within the scope of his/her license, and
- practices according to the Code of Ethics of the American Physical Therapy Association.

Policy means the written group insurance contract between us and the Policyholder.

Policyholder means the Employer to whom the Policy is issued and who sponsors the coverage for its Employees.

Rehabilitation Facility means a free-standing facility providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Doctor knowledgeable and experienced in rehabilitative medicine. A Rehabilitative Facility must meet all the following requirements:

- It is licensed and operated pursuant to law.
- It provides treatment and care for ill and injured persons on an inpatient basis.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Rehabilitation Facility includes a unit of a Hospital with beds set up and staffed and specifically designated for rehabilitative medicine.

Sickness means illness, infection, disease or any other abnormal physical condition that is not due to an Injury. Sickness includes pregnancy, infection and any other abnormal physical condition that is not caused by an Accident.

Speech Therapist means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. The Speech Therapist is trained to evaluate and treat voice, speech, language, or swallowing disorders-eg, hearing impairment, that affect speech (oral-motor-work) and communication.

Spouse means your lawful spouse. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

Urgent Care Facility means a specified area within a Hospital, or a standalone facility, licensed as an urgent care center with the state, that provides outpatient immediate and semi-urgent healthcare of non-life threatening injuries or illnesses. Urgent Care Facility does not include an Emergency Room as defined.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is:

- The Policy effective date.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The date you apply for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

CHANGE OF INSURANCE CARRIERS

If you are not in Active Employment due to Injury or Sickness or Employer-approved nonmedical leave of absence on the date the Employer changes insurance carriers to our Policy, and you were covered under the prior policy at the time the Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the prior policy's coverage must be similar to our Policy.

If you are not in Active Employment due to Injury or Sickness or Employer-approved nonmedical leave of absence on the effective date of our Policy, and you would otherwise be eligible to become insured under our Policy, we will provide limited coverage under our Policy. Coverage under this provision will begin on our Policy effective date and will continue until the earliest of the following:

- The date you return to Active Employment.
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of our Policy.

Your coverage under this provision is subject to payment of premiums.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. We will reduce our payment by any amount for which the prior carrier is liable.

If your coverage ends under this provision, or if you were not covered under the Employer's prior policy on the date that policy terminated, the EFFECTIVE DATE OF COVERAGE provision under our Policy will apply.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The last day of the month during which you are no longer in an eligible class.
- The last day of the month during which your eligible class is no longer covered.
- The last day of the month during which you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day of the month during which you are no longer in Active Employment.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, we will make a good faith effort to notify all Insured Persons at least 30 days before the termination date. We will not notify Insured Persons if we have reasonable evidence that the Policy has been or will be replaced by a substantially similar group policy, plan or contract.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate, if certain conditions are met. You must elect portability before you reach age 70.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.
- Any other continuation under the Policy ends.

Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination as described under the POLICY TERMINATION provision.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

We consider any statements the Policyholder and you make in an application to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you or your personal representative.

INCONTESTABILITY

Except in the case of fraud, no statement made by you in an application relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years during your lifetime.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

ASSIGNMENT

No assignment of benefits under the Policy is valid, unless otherwise specified in the Policy.

CHANGE OF BENEFICIARY

While your coverage is in force, you may change the beneficiary for any benefits payable for loss of life by written request on a form that is acceptable to us. A beneficiary designation form is available from the Policyholder or us. An accepted designation will take effect as of the date it is signed, unless you specify otherwise in the signed designation, but will not affect any payment we make or action we take before receiving the signed form. If an irrevocable beneficiary is named, the beneficiary designation can only be changed with the consent of the irrevocable beneficiary.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued, is automatically amended to conform to the minimum requirements of such law.

ENTIRE CONTRACT; CHANGES

The entire contract consists of all of the following:

- The Policy issued to the Policyholder including Part A and Part B.
- The Certificate(s) which are made part of Part B under the Policy.
- Any endorsements and/or riders issued.
- The Policyholder's signed application, a copy of which is attached to the Policy when issued.

The Policy may be amended at any time by written agreement between us and the Policyholder. No change in the Policy will be valid until approved by one of our executive officers. Such approval must be in writing and will be endorsed or attached to the Policy. Changes requiring regulatory approval will not be valid until approved by the appropriate regulatory body.

No agent, representative or employee of ours or of any other entity may change or waive the terms of this the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed on or attached to this the Policy.

The Policyholder may not change benefits, limit coverage or otherwise restrict participation until the Insured Persons have been notified of any changes, limitations or restrictions.

ACCIDENT BENEFITS

ACCIDENT HOSPITAL CARE BENEFITS

We will pay an ACCIDENT HOSPITAL CARE benefit (as shown in the SCHEDULE OF BENEFITS) if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Blood, Plasma, Platelets: Transfusion, administration, cross matching, typing and processing of blood, plasma, platelets administered within 90 days after a Covered Accident. This benefit is payable once per Covered Accident.

Coma: You have been in a Coma for at least 14 days. This benefit is payable once per Covered Accident.

Critical Care Unit Confinement: Confinement in a Critical Care Unit for at least 20 consecutive hours on an inpatient basis as the result of a Covered Accident. The Confinement must begin within 30 days after a Covered Accident. Benefits are payable daily for up to 15 days for a Covered Accident. Benefits are payable for only one

Critical Care Unit Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement.

If you are discharged from the Critical Care Unit and then re-Confined within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Critical Care Unit Confinement(s).

Family Care: You are Confined in a Hospital or a Rehabilitation Facility as the result of a Covered Accident, and you have a Child or Children attending a Child Care Center during that Confinement. Benefits are payable daily for up to a total of 45 days of Child Care Center attendance during and immediately following your Confinement. This benefit is payable once per Child per Covered Accident.

Hospital Admission: Admission to a Hospital as a result of a Covered Accident. The admission must begin within 6 months after a Covered Accident. This benefit is payable once per Covered Accident. No benefit is payable for any of the following:

- Emergency Room treatment.
- Outpatient Surgery.
- A stay of less than 20 hours in an observation unit.

Hospital Confinement: Confinement in a Hospital for at least 20 consecutive hours on an inpatient basis as the result of a Covered Accident. The Hospital Confinement must begin within 6 months after a Covered Accident. Benefits are payable daily for up to 365 days for a Covered Accident. Benefits are payable for only one Hospital Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement.

If you are discharged from the Hospital and then re-Confined within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Hospital Confinement(s).

Lodging: Hotel/motel stay by your companion while you are Confined in a Hospital or a Rehabilitation Facility. The Hospital/Facility must be more than 100 miles from your home. The companion must be 18 years of age or older. This benefit is payable for up to 30 days per Covered Accident.

Rehabilitation Facility Confinement: Confinement in a Rehabilitation Facility for 20 consecutive hours on an inpatient basis as the result of a Covered Accident. Benefits are payable daily for each subsequent and continuous day (or portion thereof) of inpatient Rehabilitation Facility Confinement, for up to 90 days per Covered Accident. Benefits are payable for only one Rehabilitation Facility Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement.

If you are released and readmitted to a Rehabilitation Facility within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Rehabilitation Facility Confinement(s).

Surgery: The surgery must take place within 30 days after a Covered Accident. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident. If your surgery meets more than one of the surgery classifications, the higher amount will be payable. No benefit is payable for hernia repair.

Transportation: Transportation for you for special treatment and Confinement in a Hospital or a Rehabilitation Facility. The special treatment must be prescribed by a Doctor and not available locally. The transportation must be more than 100 miles one way. This benefit is payable up to 3 trips per Covered Accident. No benefit is payable for transportation by ground ambulance or air ambulance.

ACCIDENT CARE BENEFITS

We will pay an ACCIDENT CARE benefit (as shown in the SCHEDULE OF BENEFITS) if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Ambulance, Air: Transport by a licensed professional air ambulance company to or from a Hospital or between medical facilities, for treatment of Injuries received as the result of a Covered Accident. The transport must be within 48 hours after the Covered Accident. This benefit is payable once per Covered Accident.

Ambulance, Ground: Transport by a licensed professional ambulance company to or from a Hospital or between medical facilities, for treatment of Injuries received as the result of a Covered Accident. The transport must be within 90 days after the Covered Accident. This benefit is payable once per Covered Accident.

Chiropractic Treatment: Treatment must be received by a Chiropractor in a Chiropractor's office. The treatment must begin within 90 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 6 times per Covered Accident.

Emergency Room Treatment: Examination and treatment by a Doctor in an Emergency Room within 7 days after a Covered Accident. This benefit is payable once per Covered Accident. **Exception:** If you are also eligible for an Initial Doctor Visit benefit, the Initial Doctor Visit benefit amount will be subtracted from the Emergency Room treatment benefit. If you are also eligible for an Urgent Care Facility treatment benefit, the Urgent Care Facility treatment benefit amount will be subtracted from the Emergency Room treatment benefit.

Follow-Up Doctor Treatment: Follow-up treatment by a Doctor must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is only available if you are eligible for the Initial Doctor Visit benefit or the Emergency Room treatment benefit or the Urgent Care Facility treatment benefit. This benefit is payable up to 6 times per Covered Accident.

Initial Doctor Visit: Examination and treatment by a Doctor within 14 days after a Covered Accident. This benefit is payable once per Covered Accident. **Exception:** If you are also eligible for an Emergency Room treatment benefit, the Initial Doctor Visit benefit will be subtracted from the Emergency Room treatment benefit. If you are also eligible for an Urgent Care Facility treatment benefit, the Initial Doctor Visit benefit will be subtracted from the Urgent Care Facility treatment benefit.

Major Diagnostic Exams: A major diagnostic exam must be prescribed by a Doctor and must occur within 6 months after the Covered Accident. This benefit is payable once per Covered Accident.

Medical Equipment: The medical equipment must be prescribed by a Doctor and use must begin within 6 months after the Covered Accident. This benefit is payable once per Covered Accident. The types of eligible equipment are:

- Crutches.
- Wheelchair.
- Back Brace.
- Leg Brace.
- Walker.

Outpatient Surgery: Miscellaneous surgery that is not covered by any other specific sum Injury benefit. The surgery must take place within 30 Days after a Covered Accident. Only one surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed. Only one surgery benefit is payable per Covered Accident. No benefit is payable for hernia repair.

Physical or Occupational Therapy: Therapy must be prescribed by a Doctor and provided by a Physical Therapist or by an Occupational Therapist in an office or Hospital or a Rehabilitation Facility on an inpatient or outpatient basis. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 6 times per Covered Accident.

Prosthetic Device: You receive a prosthetic device prescribed by a Doctor for use following the loss of use of a hand, a foot or the sight of an eye. The prosthetic device must be received within one year of a Covered Accident. The benefit amount varies based on the number of prosthetic devices received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident. Prosthetic devices do not include any of the following:

- Hearing aids.
- Dental aids including false teeth.
- Eye-glasses.
- Artificial joints.
- Cosmetic prostheses such as hair wigs.

Speech Therapy: Therapy for the treatment of speech and communication disorders. The approach used varies depending on the disorder. It may include physical exercises to strengthen the muscles used in speech (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

Speech therapy must be prescribed by a Doctor and provided by a Speech Therapist in an office or Hospital or a Rehabilitation Facility on an inpatient or outpatient basis. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 6 times per Covered Accident.

Urgent Care Facility Treatment: Examination and treatment by a Doctor in an Urgent Care Facility within 7 days after a Covered Accident. This benefit is payable once per Covered Accident. **Exception:** If you are also eligible for an Initial Doctor Visit benefit, the Initial Doctor Visit benefit amount will be subtracted from the Urgent Care Facility treatment benefit. If you are also eligible for an Emergency Room treatment benefit, the Urgent Care Facility treatment benefit will be subtracted from the Emergency Room treatment benefit.

X-ray: An x-ray must be prescribed by a Doctor. This benefit is payable within 90 days of a Covered Accident and is payable once per Covered Accident.

COMMON INJURIES BENEFITS

We will pay a COMMON INJURIES benefit (as shown on the SCHEDULE OF BENEFITS) if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Burns: The burn must be treated by a Doctor within 72 hours after a Covered Accident. The benefit amount varies based on the burn classification (refer to the SCHEDULE OF BENEFITS). If your burn meets more than one of the burn classifications, the higher amount will be payable. This benefit is payable once per Covered Accident.

Concussion: The concussion must be diagnosed by a Doctor within 72 hours after a Covered Accident. The diagnosis must be confirmed by the use of some type of medical imaging procedure; i.e. x-ray, CT scan or MRI.

Dislocations: The Dislocation must be diagnosed by a Doctor within 90 days after a Covered Accident. The Dislocation must require Open or Closed Reduction by a Doctor. The benefit amount will vary based on the type of services received.

- If the reduction is done without anesthesia, the benefit will be reduced to 25% of what would have been paid for a Closed Reduction of the same joint.
- If the Dislocation is incomplete, the benefit will be reduced to 25% of what would have been paid for a Closed Reduction of the same joint.

If you receive more than one Dislocation in the same Covered Accident, a benefit is payable for all Dislocations. However, the benefit will be no more than two times the benefit amount for the joint involved which pays the highest benefit amount.

If you receive a Dislocation and a Fracture in the same Covered Accident, a benefit is payable for both. However, the benefit will be no more than two times the amount for the bone or joint involved which pays the highest benefit amount.

If you receive a Dislocation or a Fracture and you tear, rupture or sever a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit is payable. The benefit payable will be the largest of either the Dislocation, the Fracture or the tendon/ligament/rotator cuff benefit.

This benefit is payable once per Covered Accident. **Exception:** Subsequent Dislocations of the same joint in a different Covered Accident are not covered.

Emergency Dental Work: Natural teeth must be damaged due to a Covered Accident and either extracted or repaired by the placement of a crown. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident regardless of the number of teeth involved.

Eye Injury: The eye Injury must be treated by a Doctor within 90 days after a Covered Accident. The Injury must require surgery or the removal of a foreign object by a Doctor. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident. No benefit is payable for examination with anesthesia or for an Injury to the Eyelid.

Fractures: The Fracture must be diagnosed by a Doctor within 90 days after a Covered Accident. The Fracture must require Open or Closed Reduction by a Doctor. If the Doctor diagnoses the Fracture as a Chip Fracture, the benefit will be reduced to a percentage of what would have been paid for a Closed Reduction of the same bone. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS).

If you receive more than one Fracture in a Covered Accident, a benefit is payable for all Fractures. However, the benefit will be no more than two times the benefit amount listed for the bone which pays the highest benefit amount.

If you receive a Fracture and a Dislocation in the same Covered Accident, a benefit is payable for both. However, the benefit will be no more than two times the amount for the bone or joint involved which pays the highest benefit amount.

If you receive a Fracture or a Dislocation and you tear, rupture or sever a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit is payable. The benefit payable will be the largest of either the Fracture, the Dislocation or the tendon/ligament/rotator cuff benefit.

Laceration: A laceration is a cut. The laceration must be treated by a Doctor within 72 hours after a Covered Accident. The benefit amount will be based on the total length of all lacerations requiring repair that are received in any one Covered Accident. If the laceration is severe enough to require stitches but the Doctor chooses to repair it another way, the benefit will be determined as if the laceration was stitched. This benefit is payable once per Covered Accident.

Paralysis: Paralysis must be confirmed by a Doctor and based on documented evidence of the Injury that caused the Paralysis. The duration of the Paralysis must be at least 30 days and expected to be permanent. The benefit amount varies based on the degree of Paralysis (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident.

Ruptured Disk: You must receive surgical repair of a ruptured disk. The ruptured disk must be treated by a Doctor within 90 days after a Covered Accident. Surgical Repair by a Doctor is required within one year after the Covered Accident. This benefit is payable once per Covered Accident.

Skin Graft: The skin graft is for a burn for which a benefit was paid under the burn benefit in this section. This benefit is payable once per Covered Accident.

Tendon/Ligament/Rotator Cuff: The tendon, ligament or rotator cuff must be torn, ruptured or severed and repaired through surgery within 90 days after a Covered Accident. The benefit amount varies based on the number of repairs required and the services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident.

If you receive a Dislocation or a Fracture and you tear, rupture or sever a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit is payable. The benefit payable will be the largest of either the Dislocation, the Fracture or the tendon/ligament/rotator cuff benefit.

Torn Knee Cartilage: You must receive surgical repair of torn knee cartilage. The Injury must be treated by a Doctor within 60 days after a Covered Accident. Surgical repair of the tear must occur within 6 months after the Covered Accident. The benefit amount varies based on the type of service received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident.

ADDITIONAL BENEFIT(S)

Sports Accident Benefit: An additional percentage of the Accident Hospital Care, Accident Care or Common Injuries benefit amount is payable if the Covered Accident is the result of an Organized Sporting Activity.

This benefit does not apply to any additional benefits provided under a separate rider.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while you are operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
- Any intentionally self-inflicted injury, other than attempted suicide, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug abuse.
- Being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.
- Riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. If any benefits are payable for loss of life, they will be paid in accordance with the beneficiary designation for such benefits and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, benefits payable for loss of life will be paid to your estate. Any other accrued benefits unpaid at your death will be paid to your estate. All other benefits will be paid to you.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

SPOUSE ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

ACCIDENT BENEFITS

The benefit amounts for your Spouse are the same as the benefit amounts for you as shown in the SCHEDULE OF BENEFITS section of the Certificate, based on your Spouse's Covered Accident.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

EFFECTIVE DATE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.
- The date you apply for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical Leave of Absence and paid time off for nonmedical-related absences.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates. See the MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE provision in this rider.
- The date this rider is terminated for all Insured Persons under the Policy.
- The last day of the month during which you voluntarily cancel this rider.
- The last day of the month during which your Spouse is no longer an eligible Spouse as defined by this rider. See the MINNESOTA CONTINUATION DEATH OR DIVORCE provision in this rider.
- The date your Spouse dies.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.

PORTABILITY

If you are approved by us to maintain your coverage under the Certificate's PORTABILITY provision, then this rider can also be maintained during portability.

MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can elect to maintain Spouse coverage if certain conditions are met. Upon your Spouse's request, the Employer will provide your Spouse with information about the cost of maintaining coverage under this provision and how to elect continuation. Your Spouse must have been insured under this rider on the date of your death or divorce, and your Spouse must elect continuation and pay the first premium within 90 days of the date of your death or divorce.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Spouse becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse.

Coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Spouse according to this rider's TERMINATION provision.
- The date your Spouse becomes covered under any group accident policy as an employee, member or spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

ACCIDENT BENEFITS

The benefits for your Spouse are the same as the benefits for you as shown in the ACCIDENT BENEFITS section of the Certificate, based on your Spouse's Covered Accident.

Only one family care benefit is payable per Child if you and your Spouse are simultaneously Confined in a Hospital or a Rehabilitation Facility.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while your Spouse is operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
- Any intentionally self-inflicted injury, other than attempted suicide, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug abuse.
- Being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.
- Riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any benefits payable for loss of life will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Any other accrued benefits unpaid at your death will be paid to your estate. All other benefits under this rider will be paid to you.

For MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits unpaid at your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CHILDREN'S ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

ACCIDENT BENEFITS

The benefit amounts for your Children are the same as the benefit amounts for you as shown in the SCHEDULE OF BENEFITS section of the Certificate, based on your Child's Covered Accident.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child for whom you or your Spouse are a legal guardian.
- Your grandchild who is financially dependent on you and resides with you continuously from birth.
- A child of your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child.

The child must also meet all of the following conditions:

- Be unmarried.
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Spouse means your lawful spouse. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

If both you and your Spouse are covered under the Policy as an Employee, then only one, but not both, may cover the same Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent who is insured as an Employee may apply for Children's coverage under this rider within 60 days.

EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you apply for Children's coverage on or before that date.
- The date you apply for Children's coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical Leave of Absence and paid time off for nonmedical-related absences.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event.

TERMINATION

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The last day of the month during which the Child reaches age 26, unless he/she is incapacitated as defined under the definition of Child. Coverage of an incapacitated Child ends when there is no longer evidence satisfactory to us that the incapacity is continuing. See the MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD provision in this rider.
- The date the Child dies.

This rider terminates on the earliest of the following:

- The date your Certificate terminates. See the MINNESOTA CONTINUATION FOLLOWING DEATH provision in this rider.
- The date this rider is terminated for all Insured Persons under the Policy.
- The last day of the month during which you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY provisions in this rider.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.

PORTABILITY

If you are approved by us to maintain your coverage under the Certificate's PORTABILITY provision, then this rider can also be maintained during portability.

MINNESOTA CONTINUATION FOLLOWING DEATH

If you die while this rider is in force, Children's coverage can be maintained if certain conditions are met. Your Children must have been insured under this rider on the date of your death. Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

If your Spouse has elected Minnesota continuation under the Spouse Accident Rider, then your Spouse may also elect continuation of this Children's Accident Rider at the same time. If you do not have an eligible Spouse insured under the Spouse Accident Rider at the time of your death, then each eligible Child insured under the Children's Accident Rider may elect Minnesota continuation and pay the first premium within 90 days of the date of your death.

Upon request of your Spouse, Child or the Child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to your Spouse, Child or Child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse, Child or Child's legal guardian as applicable.

If your Spouse or the Child's legal guardian dies while a Child's coverage is in force under this provision, then the Child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the Child's coverage under this provision.

Each Child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Child according to this rider's TERMINATION provision.
- The end of the period for which premium are paid for the Child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the Child becomes covered under any group accident policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

MINNESOTA CONTINUATION FOLLOWING DIVORCE

If you divorce and your former spouse has elected Minnesota continuation under the Spouse Accident Rider, then this Children's Accident Rider can be maintained under your former spouse's coverage for each child whose coverage would otherwise terminate due to the divorce. Upon your former spouse's request, the Employer will provide your former spouse with information about the cost of maintaining coverage under this provision and how to elect continuation.

Premiums will be billed directly to your former spouse. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your former spouse.

If your former spouse dies while a child's coverage is in force under this provision, then the child or their legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

Each child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group accident policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD

If your Child's coverage under this rider would otherwise terminate because the child no longer meets the definition of Child in this rider, for a reason other than your death or divorce, then the child can elect to maintain Child coverage under this rider for a period of time. The child (or the child's legal guardian) must elect continuation and pay the first premium within 90 days of the date of loss of eligibility.

Upon request of the child or the child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to the child or child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to the child or child's legal guardian as applicable.

If the child's legal guardian dies while the child's coverage is in force under this provision, then the child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

A child's coverage maintained under this provision will end on the earliest of the following:

- 36 months after the date continuation under this provision started.
- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group accident policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

ACCIDENT BENEFITS

The benefits for your Children are the same as the benefits for you as shown in the ACCIDENT BENEFITS section of the Certificate, based on your Child's Covered Accident. Benefits are payable for each covered Child.

No family care benefit is payable for your Child's Covered Accident.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while the Child is operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
- Any intentionally self-inflicted injury, other than attempted suicide, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug abuse.
- Being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.
- Riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any benefits payable for loss of life will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Any other accrued benefits unpaid at your death will be paid to your estate. All other benefits under this rider will be paid to you.

For MINNESOTA CONTINUATION FOLLOWING DIVORCE, benefits will be paid to your former spouse, and any accrued benefits unpaid at your former spouse's death will be paid to your former's spouse's estate. For MINNESOTA CONTINUATION FOLLOWING DEATH or PORTABILITY WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits will be payable to the person responsible for premium payments for that child, and any accrued benefits unpaid at that person's death will be payable to that person's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Children's coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER
RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse who is covered under your Spouse Accident Rider.
- Your Children who are covered under your Children's Accident Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

Temporary Layoff means you are absent from Active Employment for a period of time that has been agreed to in advance in writing by the Employer. Your normal vacation time is not considered a Temporary Layoff.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision of the Employer's prior policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Accident insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Temporary Layoff

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 9 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Other Leave of Absence

If you are on a Leave of Absence for any other reason, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 1 month after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

TEMPORARY LAYOFF

If you stop Active Employment due to a Temporary Layoff, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 1 month after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy in Active Employment.
- The date of your death.
- The date you become covered under another group Accident insurance policy as an employee or member.
- The date premiums are waived under the Waiver of Premium Rider.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, other than by waiver of premium, insurance under the Policy will stay in force only if all of the following conditions are met:

- Accident insurance is in force for Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

If coverage is not continued during any other period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

WAIVER OF PREMIUM RIDER
RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

This rider is made a part of the Group Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Total Disability or Totally Disabled means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform for remuneration or profit any other job for which you are fit by education, training or experience.

Waiting Period means the 3 month period immediately following the date you stop Active Employment during which you are continuously Totally Disabled. If you return to work for a total of 30 days or less during the Waiting Period and then stop work again due to the same Total Disability, your Waiting Period will not be interrupted.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date Accident coverage is being continued under the Certificate's PORTABILITY provision.

This rider will not terminate while premiums are being waived under the terms of this rider.

TERMINATION OF COVERAGE

The TERMINATION OF COVERAGE provision in your Certificate is revised to add this item to the terms under which your coverage ends:

- The date premiums are no longer being waived under the Waiver of Premium Rider, if you are not in an eligible class on that date.

The TERMINATION provision in your Spouse Accident Insurance Rider is revised to add this item to the terms under which your Spouse coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

The TERMINATION provision in your Children's Accident Insurance Rider is revised to add this item to the terms under which your Children's coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

WAIVER OF PREMIUM BENEFIT

If you become Totally Disabled while covered under this rider and meet the other conditions below, we will waive premiums due under the Policy and continue insurance during your Total Disability, according to the terms of this rider. When we waive premiums, the amount of continued Accident insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums that are waived are not deducted from any proceeds that may become payable.

Continued Accident insurance includes the following if effective on the date before your Total Disability began:

- Accident insurance.

Continued Accident insurance does not include:

- the Spouse Accident Insurance Rider.
- the Children's Accident Insurance Rider.
- the Catastrophic Accident Rider.
- the AD&D Rider.
- any continuation rider(s).

Any rider or coverage that is not eligible for waiver of premium under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment.

Continued insurance is subject to all other terms of the Policy.

CONDITIONS FOR WAIVER OF PREMIUM

All of the following conditions must be met in order to waive premiums:

- Total Disability begins before your 60th birthday.
- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire Waiting Period. Premiums due during the Waiting Period are subject to the continuation provision(s) of any riders.
- All premiums due for Accident insurance and this rider are paid to us through the date we approve your claim for waiver of premium or the date the continuation period under any rider ends, whichever is earlier. Premiums due are payable by the Policyholder or you as applicable.
- You provide notice of claim and proof of Total Disability to us as described below.

NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY

You must send us written notice of claim while you are living, while you are Totally Disabled, and within 12 months of the date your Total Disability begins. Failure to give notice within 12 months will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of your Total Disability. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). Claim forms are available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

EFFECTIVE DATE OF WAIVER OF PREMIUM

When we approve your claim, premiums are waived as of the date after the Waiting Period ends. We will refund any unearned premiums we receive to the Policyholder or to you, as appropriate. We will notify you in writing when your claim is approved.

We will notify you and the Employer if we deny your claim.

If we approve a claim for which notice of claim was provided to us more than 12 months after the date your Total Disability began, then any refund of unearned premiums will not exceed 12 months of premiums dating back from the date the notice of claim was received by us.

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

TERMINATION OF WAIVER OF PREMIUM

We will stop waiving premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.
- The end of the 24 month period during which your premiums are waived.

If premiums are no longer waived, insurance under the Policy will stay in force only if all of the following conditions are met:

- Accident insurance is in force for Insured Persons under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

You will not be eligible for portability under the Certificate's PORTABILITY provision on the date we stop waiving your premiums.

EXCLUSIONS

No Exclusions apply to Waiver of Premiums Benefits under this rider. All Exclusions continue to apply to the Certificate and any riders other than this rider attached to the Certificate.

CLAIMS

Except for the LEGAL ACTION provision, the CLAIMS section of the Certificate does not apply to this rider.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

AD&D BENEFITS

Accidental Death

You: \$100,000

Your Spouse: \$40,000

Your Children: \$20,000

Common Carrier

You: \$200,000

Your Spouse: \$100,000

Your Children: \$50,000

Dismemberment

Loss of both hands or both feet or the sight in both eyes:	\$40,000
Loss of one hand or one foot AND the sight in one eye	\$30,000
Loss of one hand AND one foot	\$30,000
Loss of one hand OR one foot	\$15,000
Loss of two or more fingers or toes	\$2,500
Loss of one finger or toe	\$1,500

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate and riders regarding medical conditions and eligibility apply to each Covered Person.

Common Carrier means any commercial transportation that operates on a regularly scheduled basis between predetermined points or cities.

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse who is covered under your Spouse Accident Rider.
- Your Children who are covered under your Children's Accident Rider.

GENERAL PROVISIONS**ELIGIBILITY**

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Accident Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Accident Rider terminates.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse is approved by us for Minnesota continuation under the Spouse Accident Rider, then this rider can also be continued under your Spouse's coverage along with the Catastrophic Accident Rider.

REPRESENTATIONS NOT WARRANTIES

We consider any statements you make in an application to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you, your beneficiary or your personal representative.

AD&D BENEFITS

We will pay an AD&D benefit (refer to the SCHEDULE OF BENEFITS) if a Covered Person receives any of the services or meets any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur, and the loss resulting from the Injury must begin, while the Covered Person is covered under this rider.

Accidental Death: Injuries received in a Covered Accident cause a Covered Person's death within 90 days after the Covered Accident. Your benefit is payable to your named Accidental Death beneficiary. If there is no named beneficiary, benefits will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Your Spouse's and Child's benefit is payable to you. Note: No Accidental Death benefit is payable if the Covered Person is eligible for the Common Carrier benefit.

Common Carrier: Injuries received in a Covered Accident while a Covered Person is a fare paying passenger in a Common Carrier cause the Covered Person's death within 90 days after the Covered Accident. Your benefit is payable to your named Accidental Death beneficiary. If there is no named beneficiary, benefits will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Your Spouse's and Child's benefit is payable to you.

Dismemberment: A benefit is payable to you if a Covered Person's loss (as described below) occurs within 90 days after a Covered Accident. The benefit amount varies based on the loss (refer to the SCHEDULE OF BENEFITS). The types of eligible loss under this benefit are limited to the following:

- Loss of both hands.
- Loss of both feet.
- Total and permanent loss of sight in both eyes.
- Loss of one hand or one foot AND permanent loss of sight in one eye.
- Loss of one hand AND one foot.
- Loss of one hand OR one foot.
- Loss of two or more fingers or toes.
- Loss of one finger OR one toe.

"Loss" means the physical loss of:

- A hand: the hand is removed through or above the wrist joint.
- A foot: the foot is removed through or above the ankle joint.
- Sight in an eye: total and permanent loss of sight.
- A finger: the finger is removed at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- A toe: the toe is removed at the joint proximate to the first interphalangeal joint where it is attached to the foot.

If a Covered Person loses a finger or toe and within 90 days as the result of the same Covered Accident loses a hand or foot on the same side of the body, the benefit amount payable for the loss of the finger or toe will be subtracted from the benefit payable for the loss of the hand or the foot.

If an Accident benefit is payable after laceration repair of a finger, toe, hand, foot or eye and that body part is later lost due to the same Covered Accident, the amount of the laceration repair benefit will be subtracted from the dismemberment benefit.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while you are operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
- Any intentionally self-inflicted injury, other than attempted suicide, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug abuse.
- Being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.
- Riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.

CLAIMS

Additional general claim provisions are described in the CLAIMS section of the Certificate.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PHYSICAL EXAMINATION

We may require the Covered Person to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you or your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

AUTOPSY

We may require an autopsy in case of death, at our expense, where it is not prohibited by law.

BENEFIT PAYMENTS

Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any benefits payable for loss of life will be paid according to the Accidental Death or Common Carrier provision of this rider. Any other accrued benefits unpaid at your death will be paid to your estate. All other benefits under this rider will be paid to you. For Minnesota Continuation Following Death or Divorce, any accrued benefits unpaid at your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CATASTROPHIC ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Kivi Bros Trucking, Inc.

GROUP POLICY NUMBER: 72977-9CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

CATASTROPHIC ACCIDENT BENEFIT

You:	\$100,000
Your Spouse:	\$50,000
Your Children:	\$25,000

Any Paralysis benefit paid for the same Covered Accident will be subtracted from the Catastrophic Accident benefit.

Any AD&D dismemberment benefit paid for the same Covered Accident will be subtracted from the Catastrophic Accident benefit.

EMPLOYEE CATASTROPHIC ACCIDENT BENEFIT REDUCTIONS

Your Catastrophic Accident benefit amount will decrease as follows:

- To 50% on your 65th birthday.
- To 25% on your 70th birthday.

SPOUSE CATASTROPHIC ACCIDENT BENEFIT REDUCTIONS

Your Spouse's Catastrophic Accident benefit amount will decrease as follows:

- To 50% on your Spouse's 65th birthday.
- To 25% on your Spouse's 70th birthday.

HOME MODIFICATION BENEFIT

\$2,500

VEHICLE MODIFICATION BENEFIT

\$2,500

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate and riders regarding medical conditions and eligibility apply to each Covered Person.

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse who is covered under your Spouse Accident Rider.
- Your Children who are covered under your Children's Accident Rider.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Accident Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Accident Rider terminates.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse is approved by us for Minnesota continuation under the Spouse Accident Rider, then this rider can also be continued under your Spouse's coverage along with the AD&D Rider.

CATASTROPHIC ACCIDENT BENEFIT

We will pay this benefit (refer to the SCHEDULE OF BENEFITS) to you if the loss as described below occurs within 365 days of a Covered Accident. This benefit is payable at the end of the 365 day period following a Covered Accident. The Covered Person must be receiving the appropriate care of a Doctor during the 365 day period following a Covered Accident, and the Covered Person must be alive at the end of the 365 day period. This benefit is payable once per lifetime for each Covered Person.

While the Covered Person must be covered under the Policy at the time of the Covered Accident, the Covered Person does not need to be covered at the time this benefit is paid. The benefit amount is based on the Covered Person's age at the time of the Covered Accident. The benefit amount reduces as shown on the SCHEDULE OF BENEFITS.

Losses for this benefit are limited to the total and permanent loss of any of the following:

- Both hands or both feet.
- The use of both arms or both legs.
- One hand and one foot.
- One arm and one leg.
- The sight of both eyes.
- Hearing in both ears.
- The ability to speak.

"Loss" means physical loss or loss of function:

- Of the hand through or above the wrist joint.
- Of the foot through or above the ankle joint.
- Of the entire arm from the shoulder to the hand.
- Of the entire leg from the hip to the foot.
- Of sight by total and permanent loss of sight.
- Of hearing by deafness in both ears that cannot be corrected to any functional degree by any procedure, aid or device.
- Of speech by the loss of audible communication such that it cannot be corrected to any functional degree by any procedure, aid or device.

HOME AND/OR VEHICLE MODIFICATION BENEFITS

We will pay a benefit (refer to the SCHEDULE OF BENEFITS) to you if modifications are prescribed in writing by a Doctor to be made to a Covered Person's principal place of residence and/or vehicle due to a Covered Accident for which benefits are paid under the catastrophic Accident benefit. The Doctor's written prescription must be made within 180 days of the Covered Accident. The home modification benefit is payable once per lifetime for each Covered Person. The vehicle modification benefit is payable once per lifetime for each Covered Person.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while you are operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
- Any intentionally self-inflicted injury, other than attempted suicide, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism)
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug abuse.
- Being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.
- Riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.

The catastrophic Accident benefit is not payable if the Covered Person is in a Coma at the end of the 365 day period following a Covered Accident.

CLAIMS

Additional general claim provisions are described in the CLAIMS section of the Certificate.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PHYSICAL EXAMINATION

We may require the Covered Person to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you or your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any benefits payable for loss of life will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Any other accrued benefits unpaid at your death will be paid to your estate. All other benefits under this rider will be paid to you. For Minnesota Continuation Following Death or Divorce, any accrued benefits unpaid at your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.

The mailing address is:

PO Box 20
Minneapolis, Minnesota 55440-0122
Telephone: (800) 537-5024

If you are not provided with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
(Corner of Third and Cross Street)
Little Rock, Arkansas 72201-1904

Telephone: (501) 371-2640
Toll Free in AR: (800) 852-5494

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013**

**Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921**

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association (“the Association”). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers’ care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**
 - 80% of death benefits but not to exceed \$300,000
 - 80% of cash surrender or withdrawal values but not to exceed \$100,000
- **Annuities and Structured Settlement Annuities**
 - 80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association’s website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
 - A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
 - If the person is provided coverage by the guaranty association of another state.
 - Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
 - Employer and association plans, to the extent they are self-funded or uninsured
 - A policy or contract providing any health care benefits under Medicare Part C or Part D
 - An annuity issued by an organization that is only licensed to issue charitable gift annuities
 - 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 certain investment elements of a variable life insurance policy or a variable annuity contract
 - Any policy of reinsurance unless an assumption certificate was issued
 - Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).
-

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

IDAHO CERTIFICATE ENDORSEMENT
for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. CERTIFICATE COVER PAGE

The following statements are added to the cover page of your Certificate:

Notice to Buyer: This is an Accident-only Certificate and it does not pay benefits for loss from Sickness. Review your Certificate carefully.

RENEWABILITY

The coverage under this Certificate is conditionally renewable according to the terms and provisions of the Policy.

II. EXCLUSIONS

If your Certificate and any riders contain an exclusion for felony or illegal activity, then that exclusion is replaced by the following:

- Participation in a felony.

If your Certificate and any riders contain an exclusion for intoxication while operating a motor vehicle, then that exclusion does not apply.

If your Certificate and any riders contain an exclusion for alcoholism or drug abuse, then that exclusion is replaced by the following:

- Alcoholism or drug addiction.

If your Certificate and any riders contain an exclusion for riding in or driving any motor-driven vehicle in a race, stunt show or speed test, then that exclusion does not apply.

If your Certificate and any riders contain an exclusion related to aviation, then that exclusion is replaced by the following:

- Aviation for wage or profit. Flying as a fare-paying passenger is not excluded.

If your Certificate and any riders contain any exclusions for recreational activities or competitive athletic contests, then those exclusions do not apply.

III. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes the AD&D Rider, and the Accidental Death benefit amount for Children is less than \$1,000, then that benefit amount is changed to \$1,000.

If your Certificate includes the AD&D Rider, and the Dismemberment benefit for loss of two or more fingers or toes is less than \$1,000, then that benefit amount is changed to \$1,000.

If your Certificate includes the AD&D Rider, and the Dismemberment benefit for loss of one finger or toe is less than \$500, then that benefit amount is changed to \$500.

IV. SICKNESS HOSPITAL CONFINEMENT RIDER

If your Certificate includes the Sickness Hospital Confinement Rider with a definition of Pre-Existing Condition, and that definition contains a time period of less than 6 months, then the time period in that definition is changed to 6 months.

V. OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

See the next page for the Outline of Coverage for Idaho Residents.

VI. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

ACCIDENT-ONLY COVERAGE

**THE CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES**

OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

Read Your Certificate Carefully. This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of the Policyholder, you, and ReliaStar Life Insurance Company. It is, therefore, important that you **READ YOUR CERTIFICATE CAREFULLY!**

Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

The policy provides benefits if a covered person receives any of the services or meets any of the conditions included in the "Schedule of Benefits" as a result of injuries received in a covered accident. The general categories of benefits are: Accident Hospital Care, Accident Care and Common Injuries. A partial listing of losses follows. Please consult your certificate and riders for specific information about how these terms are used, any requirements that describe qualifying for a particular loss, and the benefit amounts. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of benefits available under the policy.

- Accident Hospital Care includes: surgery; blood, plasma, platelets; hospital admission; hospital confinement; coma; transportation; and lodging. At the Policyholder's option, it may also include: critical care unit confinement, rehabilitation facility confinement; or family care benefits.
- Accident Care includes: medical equipment; physical or occupational therapy; and prosthetic devices. At the Policyholder's option, it may also include: initial doctor visit; urgent care facility treatment; emergency room treatment; ambulance benefits; follow-up doctor treatment, chiropractic care; speech therapy; major diagnostic exams; or x-rays.
- Common Injuries includes: burns; skin grafts; emergency dental work; eye injuries; torn knee cartilage; lacerations; ruptured disk; tendon/ligament/rotator cuff; concussion; paralysis; dislocations and fractures.

Accident-only coverage is subject to exclusions which may prevent benefits from being paid. Also, benefit payment is contingent on proof of loss which may require additional information be provided prior to claim determination, and there is generally a requirement that services or conditions be met within a certain time period following a covered accident. The Policyholder may also choose to have an eligibility waiting period, during which time no coverage is in force. **Riders may have benefit reductions or termination provisions based on age.**

The exclusions that apply to all provisions for Accident-only coverage are provided in the "Exclusions" section of the certificate and any riders. The "Schedule of Benefits", the Benefits section(s) and the "Exclusions" section of the certificate and any riders provide specific information about the conditions for receiving benefits and any limitations. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of the exclusions and limitations under the policy.

Exclusions in the certificate:

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation in a felony.
- Suicide, attempted suicide or any intentionally self-inflicted injury, while sane or insane.
- War or any act of war, whether declared or undeclared (other than acts of terrorism).
- Service in the armed forces or units auxiliary to it. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug addiction
- Aviation for wage or profit. Flying as a fare-paying passenger is not excluded.
- Any sickness or declining process caused by a sickness.

Your coverage will continue under the policy, while the policy remains in force, as long as you continue to meet the eligibility requirements and all premiums due are paid. You may have the option to continue your coverage by direct payment of premiums to ReliaStar Life Insurance Company after you no longer meet the eligibility requirements.

The eligibility requirements for a spouse and children may include age limitations, as provided in the riders. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of any age restrictions under the policy.

The Policyholder may change the terms of the policy at any time with ReliaStar Life Insurance Company's agreement. The Policyholder or ReliaStar Life Insurance Company may terminate the policy at any time. ReliaStar Life Insurance Company reserves the right to change premiums at any time according to the terms of the policy.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MAINE CERTIFICATE ENDORSEMENT
for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following are added after the TERMINATION OF COVERAGE provision:

If your coverage ends due to a lapse or default on your part, your coverage may be reinstated on the basis that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. You or someone authorized to act on your behalf must submit a request for reinstatement to us within 90 days of cancellation along with medical proof, at your expense, that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. Within 15 days of our request, all premiums due from the date of cancellation must also be received by us in order to consider your request for reinstatement. If we approve your request, your coverage will be reinstated at the same level as though the cancellation had not occurred.

THIRD PARTY NOTICE

You may designate an additional person to receive notice of any intent to terminate coverage. You may change this designation at any time. The form is available upon request from the Policyholder.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
20 Washington Avenue South
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to \$500,000. Subject to this \$500,000 limit, the Guaranty Association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, \$500,000 in disability income insurance, \$250,000 in annuity net cash surrender and net cash withdrawal values, \$410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MONTANA CERTIFICATE ENDORSEMENT
for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. NEWBORN CHILDREN

If you are covered under the Policy, your eligible newborn Child is automatically covered for the first 31 days after birth. The benefit amount is the same amount indicated on the Children's Accident Rider for all eligible Children.

No Benefit Waiting Period in any riders applies to your eligible newborn Child.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

NOTICE OF PROTECTION PROVIDED BY NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies. For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
 - \$300,000 in death benefits
 - \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans (see definition below)
 - \$300,000 in disability income insurance benefits
 - \$300,000 in long term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of type of coverage, is \$300,000; however, may be up to \$500,000 with regard to health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTC).

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life policy or annuity contract to which it relates.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org, or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota, 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit, or induce you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

**NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association (“the Association”). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers’ care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to \$300,000 (or \$500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to \$300,000 in death benefits including up to \$100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to \$500,000 for health benefit plans, with some exceptions.
- Up to \$300,000 for disability income benefits.
- Up to \$300,000 for long-term care insurance benefits.
- Up to \$100,000 for all other types of health insurance.

Individual Annuities

- Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by 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, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SOUTH DAKOTA CERTIFICATE ENDORSEMENT
for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

The definition of **Doctor** is changed to add the following statement:

Doctor includes a family member if the family member is the only Doctor in your area provided the Doctor is acting within the scope of his/her practice.

II. GENERAL PROVISIONS

If your Certificate includes a PORTABILITY provision and that provision states that we may change the portability premium rates at any time with less than 45 days written notice, then this time period is changed to be 45 days.

The same time period change applies to any PORTABILITY FOLLOWING DEATH OR DIVORCE provision if you have a Spouse Accident Rider, and to any PORTABILITY FOLLOWING DEATH provision if you have a Children's Accident Rider.

III. ACCIDENT BENEFITS

There is no requirement for you to be Confined for a specific number of hours in order to receive a Hospital Confinement benefit. This also applies to any Critical Care Unit Confinement benefit and/or any Rehabilitation Facility Confinement benefit. We will pay a benefit for any eligible Confinement.

IV. EXCLUSIONS

If your Certificate or any riders contain an exclusion for operating a motorized vehicle while intoxicated, then this exclusion does not apply.

If your Certificate or any riders contain an exclusion for alcoholism or drug abuse, then this exclusion does not apply.

If your Certificate or any riders contain an exclusion for work-related Accidents, then the exclusion is changed to the following:

- Work for pay, profit or gain for which benefits are paid under workers' compensation or similar law.

V. OFF JOB ACCIDENT DISABILITY INCOME RIDER

If your Certificate includes an Off Job Accident Disability Income Rider, then the work-related exclusion on that rider is changed to the following:

No monthly benefit is payable for disability caused in whole or directly by any work for pay, profit or gain for which benefits are paid under workers' compensation or similar law.

VI. SICKNESS HOSPITAL CONFINEMENT RIDER

If your Certificate includes a Sickness Hospital Confinement Rider with a definition of **Pre-Existing Condition**, and that definition has a time period of more than 6 months, then this time period is changed to be 6 months.

If your Certificate includes a Sickness Hospital Confinement Rider, then the first exclusion under the EXCLUSIONS provision is changed to the following:

- Services are received for a Hospital stay for which there is no charge for room and board.

If your Certificate includes a Sickness Hospital Confinement Rider, and the EXCLUSIONS provision contains an exclusion for alcoholism or drug abuse, then this exclusion does not apply.

VII. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota 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 members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy owners, contract owners, and certificate owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association 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. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and required continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy or contract.

Coverage is NOT provided for your policy or contract for any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy or contract.

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

(Please turn to back of page)

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below 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 anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are 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);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy owner, contract owner or certificate owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D Coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than \$300,000 in death benefits and not more than \$100,000 in net cash surrender and net cash withdrawal values; (ii) for health benefit plans, not more than \$500,000, but not more than \$300,000 for disability insurance and long term care insurance, and not more than \$100,000 for other types of health insurance, and (iii) for annuities, not more than \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of \$300,000 in benefits with respect to any one life except with respect to health benefit plans, for which the aggregate liability of the guaranty association may not exceed \$500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

TEXAS CERTIFICATE ENDORSEMENT
for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate includes a definition of **Child** or **Children**, then this definition is changed as follows:

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date you are eligible for coverage. The definition also includes a child for whom you must provide medical support under a court order.

II. CHILDREN'S ACCIDENT RIDER

If your Certificate includes a Children's Accident Rider, then the definition of **Child** or **Children** on the rider is changed as follows:

If the definition includes a minimum Child age of 14 days, then this minimum is changed to birth.

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date the grandchild is first eligible under this rider. The definition also includes a child for whom you must provide medical support under a court order.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

III. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

Texas Residents: 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.

ReliaStar Life Insurance Company

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

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 20 Washington Avenue South, Minneapolis, MN 55401

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 149091, Austin, TX 78714-9091

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

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

ReliaStar Life Insurance Company

Para obtener informacion o para presentar una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 20 Washington Avenue South, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada 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 electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

WASHINGTON CERTIFICATE ENDORSEMENT
for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. ACCIDENT HOSPITAL CARE BENEFITS

The time period in the **Blood, Plasma, Platelets** provision between the Covered Accident and transfusion is changed to one year.

If your Certificate includes a **Critical Care Unit Confinement** benefit, then the time period in that provision between the Covered Accident and Confinement is changed to one year.

The time period in the **Hospital Admission** provision between the Covered Accident and admission is changed to one year.

The time period in the **Hospital Confinement** provision between the Covered Accident and Hospital Confinement is changed to one year.

The time period in the **Surgery** provision between the Covered Accident and surgery is changed to one year.

II. ACCIDENT CARE BENEFITS

If your Certificate includes an **Ambulance, Air** benefit, then the time period in that provision between the Covered Accident and transport is changed to one year.

If your Certificate includes an **Ambulance, Ground** benefit, then the time period in that provision between the Covered Accident and transport is changed to one year.

If your Certificate includes a **Chiropractic Treatment** benefit, then the time period in that provision between the Covered Accident and the examination and treatment is changed to one year. The time period between the Covered Accident and the completion of treatment is changed to 18 months.

If your Certificate includes an **Emergency Room Treatment** benefit, then the time period in that provision between the Covered Accident and treatment is changed to one year.

If your Certificate includes a **Follow-Up Doctor Treatment** benefit, then the time period in that provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and the completion of treatment is changed to 18 months.

If your Certificate includes an **Initial Doctor Visit** benefit, then the time period in that provision between the Covered Accident and treatment is changed to one year.

If your Certificate includes a **Major Diagnostic Exams** benefit, then the time period in that provision between the Covered Accident and the exam is changed to one year.

The time period in the **Medical Equipment** provision between the Covered Accident and the beginning use of the prescribed medical equipment is changed to one year.

The time period in the **Outpatient Surgery** provision between the Covered Accident and the surgery is changed to one year.

The time period in the **Physical or Occupational Therapy** provision between the Covered Accident and the beginning of therapy is changed to one year. The time period between the Covered Accident and the completion of therapy is changed to 18 months.

If your Certificate includes a **Speech Therapy** benefit, then the time period in that provision between the Covered Accident and the beginning of therapy is changed to one year. The time period between the Covered Accident and the completion of therapy is changed to 18 months.

If your Certificate includes an **Urgent Care Facility Treatment** benefit, then the time period in that provision between the Covered Accident and the examination and treatment is changed to one year.

If your Certificate includes an **X-ray** benefit, then the time period in that provision between the Covered Accident and the prescription is changed to one year.

III. COMMON INJURIES BENEFITS

The time period in the **Burns** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Concussion** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Dislocations** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Eye Injury** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Fractures** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Laceration** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Ruptured Disk** provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and surgical repair is also changed to one year.

The time period in the **Tendon/Ligament/Rotator Cuff** provision between the Covered Accident and surgical repair is changed to one year.

The time period in the **Torn Knee Cartilage** provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and surgical repair is also changed to one year.

IV. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes an AD&D Rider, then the following changes apply:

The time period in the **Accidental Death** provision between the Covered Accident and death is changed to one year.

The time period in the **Common Carrier** provision between the Covered Accident and death is changed to one year.

The time period in the **Dismemberment** provision between the Covered Accident and loss is changed to one year.

The time period in the **Dismemberment** provision between the Covered Accident and loss of a finger or toe and subsequent loss of a hand or foot on the same side of the body is changed to one year.

V. CATASTROPHIC ACCIDENT RIDER

If your Certificate includes a Catastrophic Accident Rider, then the following changes apply:

The time period in the CATASTROPHIC ACCIDENT BENEFIT section between the Covered Accident and loss is changed to one year.

If the Catastrophic Accident Rider includes a **Home Modification Benefit** and/or a **Vehicle Modification Benefit**, then the time period in the HOME AND/OR VEHICLE MODIFICATION BENEFITS section between the Covered Accident and the prescription is changed to one year.

VI. EXCLUSIONS

If the EXCLUSIONS section of your Certificate and any riders has exclusions for intoxication, alcoholism and/or drug abuse, then these exclusions do not apply.

VII. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

Wisconsin Complaint Notice

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

**ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-877-236-7564**

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE**

at its website at <http://oci.wi.gov/>,

or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:

Kivi Bros Trucking Plan
72977-9CAC2
Kivi Bros Trucking, Inc.
5739 Old Highway 61
Duluth, MN 55810

Name, Address, and Telephone Number of the Plan Administrator:

Kivi Bros Trucking, Inc.
5739 Old Highway 61
Duluth, MN 55810
N/A

Identification Numbers

IRS Employer Identification Number: 41-1769272
Plan Number: 501

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: July 1 through June 30

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

- 1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
- 2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
- 3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
- 4) The notice of denial will be written in an understandable manner and include the following:
 - a. The specific reason(s) for the denial.
 - b. Specific reference to the provision which forms the basis of the denial.
 - c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
 - d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
- 5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
- 6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
- 7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
- 8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR WAIVER OF PREMIUM RIDER

- 1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
- 2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
- 3) Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
- 4) The notice of denial will be written in an understandable manner and include the following:
 - a. The specific reason(s) for the denial.
 - b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
 - c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
 - d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
- 5) The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
- 6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
- 7) Prior to rendering an adverse decision on appeal, ReliaStar Life will provide notice to the claimant of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. ReliaStar Life Insurance Company of New York will also notify the claimant if it has new or additional rationale for an adverse appeal determination. ReliaStar Life Insurance Company of New York will then provide the claimant with a reasonable opportunity to review and respond to this new information before making its decision. The time period ReliaStar Life Insurance Company of New York has to make its determination will be tolled while it is waiting for the claimant's response.
- 8) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. If ReliaStar Life Insurance Company of New York sends an adverse benefit determination following its review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
 - a. The specific reason(s) for the adverse benefit determination.
 - b. Reference to the specific provision on which the determination is based.
 - c. A statement that the claimant is 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.
 - d. A statement of the claimant's right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
 - e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of

charge.

- f. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

- 9) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

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). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, 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.