



**UnitedHealthcare<sup>®</sup>  
Specialty Benefits<sup>SM</sup>**

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**GROUP LONG TERM DISABILITY  
CERTIFICATE OF COVERAGE**

**FOR**

**LOS ANGELES POLICE RELIEF ASSOCIATION, INC.**

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**POLICY NUMBER: 302292**

**EFFECTIVE DATE: July 1, 2009**

If there is a discrepancy between the provisions of the Policyholder's online or printed Certificates and the provisions of the Certificates furnished by the Company, the provisions of the Group Policy will prevail.

CA – ULIC

Class 2 – Members of LAPRA  
(5-11)

**Unimerica Life Insurance Company**  
**(Hereinafter referred to as We, Us or Our)**  
**A Stock Company**

**Administrative Offices: 6300 Olson Memorial Highway, Golden Valley, MN 55427**

**Phone: 1-866-615-8727**

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**Policyholder:** Los Angeles Police Relief Association, Inc.

**Effective Date:** July 1, 2009

**Policy Number:** 302292

We, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person. This Certificate becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above.

**Read the Group Certificate Carefully**

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-800-554-5413.

It is signed at Our Home Office of as of the Effective Date shown above.



Timothy F. Ryan, Secretary



Diane D. Souza, Chief Executive Officer

**Group Long Term  
Disability, Insurance Policy  
Non-Participating**

**The Consumer Services Division should be contacted after discussions with the insurer, its agent or other representatives, or both, have failed to satisfactorily resolve a consumer problem at: 300 S. Spring Street, Los Angeles, CA 90013. The phone number is: 1-800-927-HELP.**

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## SCHEDULE OF BENEFITS

### Class of Members

This schedule covers the following class(es) of Members of companies and affiliates controlled by the Policyholder:

All active full-time recruits employed by the City of Los Angeles to become sworn police officers and all sworn police officers of the Los Angeles Police Department who are in good standing with the Employer.

### Description of Class:

Members are considered full-time if they customarily work: 30 hours per week

**Member Waiting Period:** The date he becomes a Member

**Cost of Insurance:** The Covered Person is required to contribute to the cost of his insurance.

### Benefits:

#### Long Term Disability Benefit:

**Disability Earnings** means the earnings, which the Covered Person receives, while Residually Disabled.

**Maximum Monthly Benefit:** \$600

**Minimum Monthly Benefit:** None

**Elimination Period:** 30 days. Benefits begin the day after completion of the Elimination Period.

**Accumulation of Elimination Period:** 5 days

**Elimination Period** means the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability. If the Covered Person returns to work for a period of time not to exceed the Accumulation of Elimination Period and cannot continue, he will not have to begin a new Elimination Period. However, We will count only those days he is Partially Disabled toward satisfying the Elimination Period.

#### Maximum Benefit Period:

- **For Disability Due to Injury:** For the duration of the Disability
- **For Disability due to any other cause:** For the duration of the Disability

Premium contributions are waived while the Covered Person is receiving Long Term Disability payments.

## COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

**Covered Person's Eligibility:** Members who work on a full-time basis for the Employer are eligible for insurance after completion of the required Member Waiting Period shown in the Schedule of Benefits, provided they are in a class of Members who are included. Members will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

A Member will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Member Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Member's class; or
4. the date the Member enters a class eligible for insurance.

**Effective Date of Covered Person Insurance:** If a Member is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day he returns to Active Work. If the Member's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

A Member must use forms provided by Us when applying for insurance.

The Member's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Member becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Member makes application within 31 days after the date he first became eligible, on the later of:
  - a. the date the Member is eligible for insurance, regardless of when he applies; or
  - b. the date the Member's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if a Member applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class, except if he was in "off-payroll" status for a period of less than six months.

**Termination of Covered Person Insurance:** The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard Time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the last day of the month during which he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the last day of the month during which he ceases to be Actively at Work. The Policyholder may deem the Covered Person's employment continued during a temporary layoff or approved leave of absence. In such cases, insurance will not continue, except as follows:
  - a. if active work ceases during an approved medical leave of absence, the Long Term Disability Insurance will continue for up to 3 months from the date he stopped active work;

**COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS  
(continued)**

- b. if a Member is “off –payroll” due to suspension of duties, the Long Term Disability Insurance will continue for up to 12 months from the date he stopped active work;
- c. if a Member is “off-payroll” due to any leave of absence, other than suspension, the Long Term Disability Insurance will continue until the end of the leave.

## LONG TERM DISABILITY INSURANCE FOR COVERED PERSON

### **Disability Provision:**

We will pay the monthly benefit for each month that the Covered Person is continuously Disabled provided the period of Disability begins while covered under the Policy and continues beyond the Elimination Period.

**Disabled or Disability** means Total Disability or Residual Disability as those terms are defined below.

**Elimination Period** means the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability. If the Covered Person returns to work for a period of time not to exceed the Accumulation of Elimination Period and cannot continue, he will not have to begin a new Elimination Period. However, We will count only those days he is Totally/Partially Disabled toward satisfying the Elimination Period. The Elimination Period and the Accumulation of Elimination Period are shown in the Schedule of Benefits.

**Totally Disabled or Total Disability** means that during the first 12 months of a period of Disability The Covered Person has a Disability that renders him unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way.

After the first 12 months of a period of Disability and for the duration of his Disability, The Covered Person has a Disability that renders him unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

**Residual Disability** means that following a period of Total Disability for which benefits are payable under this Policy, he is now able to:

1. perform with reasonable continuity one or more of the substantial and material acts necessary to pursue his regular occupation in the usual and customary way, but he is unable to perform all of the substantial and material acts or he is unable to perform them for as long as normally required.
2. perform with reasonable continuity one or more of the substantial and material acts necessary to engage in another occupation which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity, but he is unable to perform all of the substantial and material acts or he is unable to perform them for as long as normally required.

In order to determine Disability, We may require the Covered Person to be examined by Physicians, other medical practitioners or vocational experts of Our choice. We will pay for these examinations.

The Benefit Percent, Elimination Period, Maximum Benefit Period and Maximum Monthly Benefit are shown in the Schedule of Benefits.

**Receipt of Disability Payments:** The Covered Person will begin to receive payments when We approve his claim, provided the Elimination Period has been met and he is Disabled. We will send him a payment each month for any period for which We are liable. If he is Residually Disabled, proof of Disability Earnings will be required before benefits are paid.

After the Elimination Period, if the Covered Person is Disabled for only part of a month, We will send him 1/30<sup>th</sup> of his payment for each day of Disability.

**Disability Earnings** means the earnings, which the Covered Person receives while Residually Disabled.

**LONG TERM DISABILITY INSURANCE FOR COVERED PERSON**  
**(continued)**

**Other Income Benefits:**

1. any benefits and awards he receives under:
  - a. occupational disease Law; or
  - b. any other similar Act or Law.
2. any temporary disability benefits he receives under Workers' Compensation Law;

If the Covered Person receives any of the Other Income Benefits in a lump sum payment, We will pro-rate the lump sum on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis to the end of the Covered Person's Maximum Benefit Period.

Other Income Benefits must be payable as a result of the same Disability for which the Covered Person is receiving a payment from Us, except for retirement benefits.

We will NOT subtract from the Covered Person's Gross Disability Payment any amounts he receives from the following sources:

1. 401(k) plans
2. profit sharing plans
3. thrift plans
4. tax sheltered annuities
5. stock ownership plans
6. non-qualified plans of deferred compensation
7. Pension plans for partners
8. military pension and military disability income plans
9. credit disability insurance
10. franchise disability income plans
11. a retirement plan from another Employer
12. Individual Retirement Accounts (IRA)
13. individual disability income plans

**Affect of Other Income Benefits on Payment:** If subtracting Other Income Benefits results in a zero benefit, We will pay the Covered Person the Minimum Monthly Benefit shown in the Schedule of Benefits. The Minimum Monthly Benefit, however, may be applied toward an outstanding overpayment.

**Cost of Living Increases:** After the first deduction for each of the Other Income Benefits, We will not further reduce the amount of the Covered Person's Monthly Payment under the Policy due to cost of living increases he receives from any of the sources described in the "Other Income Benefits" section.

**Lump Sum Survivor Benefit:** When We receive proof that the Covered Person died, We will pay his spouse, if living, otherwise, his children under age 25, a lump sum benefit equal to 3 months of the Covered Person's monthly Gross Disability Payment if, on the date of the Covered Person's death:

1. his Disability had continued for 30 or more consecutive days; and
2. he was receiving or was entitled to receive a Monthly Payment under the Policy.

If the Covered Person has no living spouse or children, payment will be made to his estate. However, We will first apply the survivor benefit to any overpayment which may exist on the Covered Person's claim.



**LONG TERM DISABILITY INSURANCE FOR COVERED PERSON**  
**(continued)**

**Termination of Benefits:** We will stop sending the Covered Person payments and his claim will end on the earliest of:

1. the date he is no longer Disabled according to the terms of the Policy;
2. the date he reaches the end of the Maximum Benefit Period stated in the Schedule of Benefits;
3. the date he dies.

If the Covered Person is a citizen of the United States and is receiving Treatment outside of the United States, We may require him to return to the United States for Treatment. Failure to do so when requested may result in termination of benefits.

**General Limitations:**

**Mental Illness Limitation**

Disabilities due to Mental Illness have a limited pay period of 12 months. This is a lifetime cumulative maximum benefit period for Disabilities due to Mental Illness.

We will continue to send the Covered Person payments beyond the limited pay period if he is confined to a Hospital or Medical Facility. If he is still Disabled when he is discharged, We will send him payments for a recovery period of up to 90 days. If he becomes re-confined at any time during the recovery period and remains confined for at least 14 days in a row, We will send payments during that additional confinement and for one additional recovery period up to 90 more days.

In no case will benefits be paid beyond the Maximum Benefit Period stated in the Schedule of Benefits.

**Mental Illness** means any condition which is:

1. listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
2. usually treated by a mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of treatment.

**Substance Abuse Limitation**

Benefits payable for loss sustained or contracted in consequence of Your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician, have a limited pay period of 12 months. This is a lifetime cumulative maximum benefit period for Disabilities due to Substance Abuse.

We will continue to send the Covered Person payments beyond the limited pay period if he is confined to a Hospital or Medical Facility. If he is still Disabled when he is discharged, We will send him payments for a recovery period of up to 90 days. If he becomes re-confined at any time during the recovery period and remains confined for at least 14 days in a row, We will send payments during that additional confinement and for one additional recovery period up to 90 more days.

In no case will benefits be paid beyond the Maximum Benefit Period stated in the Schedule of Benefits.

**Recurrent Disability:** If the Covered Person's current Disability is due to the same or related medical causes as a prior Disability for which We made a payment, We will treat the current Disability as part of his prior claim if less than 6 consecutive months have passed since the prior Disability. The current Disability will be subject to the same terms of the Policy as the prior claim and will be treated as a continuation of that Disability, except the Covered Person will not be required to satisfy another Elimination Period.

Any Disability which occurs after 6 consecutive months from the date of the Covered Person's prior claim ended will be treated as a new claim. The new claim will be subject to all of the provisions of the Policy, including the Elimination Period.

**LONG TERM DISABILITY INSURANCE FOR COVERED PERSON  
(continued)**

If the Covered Person returns to work for another Employer, We will treat a Recurrent Disability the same as established above for the first 6 months following his return to work. Any Recurrent Disability that occurs more than 6 months but less than 12 months after the end of the Covered Person's prior Disability will be treated as a continuation of the prior Disability, but the Covered Person will be required to complete a new Elimination Period.

**Multiple Causes:** If a period of Disability is extended by a new, unrelated cause while benefits are payable, benefits will continue while the Covered Person remains Disabled, subject to the following:

1. benefits will not continue beyond the end of the original Maximum Benefit Period; and
2. any Exclusions and Pre-existing Conditions Limitations will apply to the new cause of Disability.

**Concurrent Disabilities:** Benefits for a Disability that is caused by more than one condition will be paid as if the Disability were caused by one condition. In no event will a Covered Person be considered to have more than one Disability at the same time.

**General Exclusions:** We will not cover a Disability under the Policy if it is due to:

1. an act of war, declared or undeclared, whether civil or international;
2. intentionally self-inflicted injuries;
3. active participation in a riot; or
4. committing or attempting to commit a felony.

If the Covered Person becomes entitled to benefits under any other Group Long Term Disability policy, he will not be eligible for payments under the Policy.

**Continuity of Insurance Upon Transfer of Insurance Carriers:** In order to prevent loss of insurance for a Covered Person because of a transfer of insurance carriers, We will provide insurance for certain Members as follows:

Members who are not Actively at Work due to Disability:

We will insure the Member under this Policy if the prior group insurance policy insured him and the cost of his insurance under the prior group insurance policy was paid.

Our payments to the Member will be limited to the lesser of the Monthly Payment under the Policy or the monthly benefit the prior group insurance policy would have paid him, had that policy stayed in effect. Our payments will be reduced by any amount the prior group insurance policy is responsible for paying.

## CERTIFICATE GENERAL PROVISIONS

**Entire Group Contract; Changes:** This Policy, the application of the Policyholder, if any, and the individual applications, if any, of the Members, constitute(s) the entire contract between the parties, and any statement made by the Policyholder, or by any Member shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void the Policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Member eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or Disability commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in the Policy shall be valid unless approved by an executive officer of Ours and unless such approval be endorsed thereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

**Time Limit on Certain Defenses:** No claim for loss incurred or Disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

**Grace Period:** A grace period of 60 days from the Premium Due Date will be granted for the payment of premiums accruing after the first premium, during which grace period, the Policy will continue in force, but the Policyholder shall be liable for the payment of the premium accruing for the period the Policy continues in force.

**Notice of Claim:** Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at the administrative address shown on the face page of this Certificate, or to any authorized agent of Ours, with information sufficient to identify the insured Member (i.e. Name, the Policyholder's name and the Policy number) shall be deemed notice to Us.

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

**Proofs of Loss:** Written proof of loss must be furnished to Us, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the date the Elimination Period ends, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

**Time of Payment of Claim:** Indemnities payable under the Policy for any loss other than loss for which this Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this Policy provides periodic payment will be paid to the insured member monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

**CERTIFICATE GENERAL PROVISIONS**  
**(Continued)**

**Payment of claims:** Indemnity for loss of life will be payable in accordance with the beneficiary designation 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, such indemnity shall be payable to Your estate. Any other accrued indemnities unpaid at Your death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to You.

If any indemnity of this Policy shall be payable to the estate of the insured Member, or to an insured Member or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the insured Member or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

**Physical Examination and Autopsy:** We, at Our own expense, shall have the right and opportunity to examine the person of any individual whose condition is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

**Legal Actions:** No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**Misstatement of Age:** If the age of any individual covered under this Policy has been misstated, the amount payable shall be such as the premium paid for would have purchased at the correct age.

**Cancellation:** After the Policy has been in force for 12 months, We may cancel this Policy at any time by written notice delivered to the Policyholder, or mailed to its last address as shown on Our records, stating when, not less than 60 days thereafter, such cancellation shall be effective; and the Policyholder may cancel this Policy at any time by written notice delivered or mailed to Us, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on a prorata basis the earned premium which has not been paid. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

**Conformity with State Statutes:** Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

**Right to Audit:** While We are paying benefits, We have the right to audit Your earnings at reasonable intervals if You are Disabled and working.

## GLOSSARY OF TERMS

The male pronoun, whenever used in the Policy, includes the female.

**Active Work or Actively at Work:** The Covered Person is working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

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

**Contributory or Non-Contributory Insurance:** Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

**Covered Person:** The Member insured under the Policy. References to "Covered Person", "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

**Disabled or Disability:** Total Disability or Residual Disability as those terms are defined in the Disability Benefit Provisions.

**Employer:** The Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

**Hospital or Medical Facility:** A legally operated, accredited facility licensed to provide full-time care and treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

**Physician:** A practitioner of the healing arts who is:

1. duly licensed and practicing in the United States and in the state in which the treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's spouse, children, parents, parents-in-law, or siblings.

## **California Consumer Complaint Notice**

If the Covered Person has any questions or problems with their coverage, We will be ready to help. Our contact information is:

**Unimerica Life Insurance Company  
A Stock Company**

**Administrative Offices: 6300 Olson Memorial Highway, Golden Valley, MN 55427  
1-866-615-8727**

The Covered Person may also call the California Department of Insurance for assistance. However, We ask that the Covered Person gives Us the opportunity to try to resolve the problem. Please, call us first. If, We fail to help, the Covered Person may still ask the California Department of Insurance for assistance. Their contact information is:

**California Department of Insurance  
Consumer Services Division  
300 South Spring Street  
Los Angeles, California 900013  
1-800-927-HELP  
(1-800-927-4357)**

**Unimerica Life Insurance Company**

**A Stock Company**

**Administrative Offices: 6300 Olson Memorial Highway, Golden Valley, MN 55427**

**Phone: 1-866-615-8727**

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**Policyholder:** Los Angeles Police Relief Association, Inc.

**Effective Date:** July 1, 2009

**Policy Number:** 302292

**Beneficiary:** As on file with the Administrator

We, Unimerica Life Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person. This Certificate becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above.

**Read the Group Certificate Carefully**

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

It is signed at the Home Office of Unimerica Life Insurance Company as of the Effective Date shown above.



Timothy F. Ryan, Secretary



Diane D. Souza, Chief Executive Officer

**Group Accidental Death and  
Dismemberment Insurance Policy  
Non-Participating**

**The Consumer Services Division should be contacted after discussions with the insurer, its agent or other representatives, or both, have failed to satisfactorily resolve a consumer problem at: 300 S. Spring Street, Los Angeles, CA 90013. The phone number is: 1-800-927-HELP.**

## SCHEDULE OF BENEFITS

### **Class of Members**

This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Employer:

All active full-time recruits employed by the City of Los Angeles who become a sworn police officer and all sworn police officers of the Los Angeles Police Department who are in good standing with the Employer.

### **Description of Class:**

Members are considered full-time if they customarily work: 30 hours per week

**Member Waiting Period:** The date he becomes a Member

A Member is eligible for insurance on the later of the following dates:

1. The Policyholder's Effective Date, July 1, 2009.
2. The date the Covered Person begins continuous full-time employment with the Employer.

**Cost of Insurance:** The Covered Person is not required to contribute to the cost of his AD&D Insurance.

### **Covered Person Insurance:**

#### **Accidental Death and Dismemberment Benefit:**

\$2,000



## GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

**Active Work or Actively at Work:** The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

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

**Contributory or Non-Contributory Insurance:** Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

**Covered Person:** The Member insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

**Member:** A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Employer will be considered a Member unless he meets the above conditions.

**Employer:** The Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

**Hospital or Medical Facility:** A legally operated, accredited facility licensed to provide full-time care and treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

**Physician:** A practitioner of the healing arts who is:

1. duly licensed in the state in which the treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's Spouse, children, parents, parents-in-law, or siblings.

**We, Our and Us:** Unimerica Life Insurance Company.

## GENERAL PROVISIONS

**Entire Group Contract; Changes:** The master group insurance Policy, the application of the Policyholder, if any, and the individual applications, if any, of the persons eligible for coverage, constitute(s) the entire contract between the parties, and any statement made by the Policyholder, or by any individual eligible for coverage under the Policy, shall, in the absence of fraud, be deemed a representation and not a warranty.

No such statement shall void the insurance or reduce the benefits under the Policy or be used in defense to a claim hereunder unless it is contained in a written application.

No change in the Policy shall be valid unless approved by an executive officer of Ours and unless such approval be endorsed thereon or attached thereto. No agent has authority to change the Policy or to waive any of its provisions.

**Time Limit on Certain Defenses:** No claim for loss incurred or commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

**Notice of Claim:** Written notice of claim must be given to Us within 30 days of the date of death or the date injury occurred, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at the administrative address shown on the face page of this Certificate, with information sufficient to identify the Covered Person (i.e. name, the Policyholder's name and the Policy number) shall be deemed notice to Us.

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

**Proofs of Loss:** Written proof of loss must be furnished to Us, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Member, later than one year from the time proof is otherwise required.

**Time of Payment of Claim:** Indemnities payable under the Policy for any loss other than loss for which this policy provides periodic payments will be paid to the Covered Person as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid to the Covered Person monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

**Payment of Claims:**

Indemnity for loss of a Member's life will be payable in accordance with the beneficiary designation 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, such indemnity shall be payable to the Covered Person's estate. Any other accrued indemnities unpaid at death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

## GENERAL PROVISIONS (continued)

If any indemnity of this policy shall be payable to a Covered Person's estate, or to any person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding \$1,000 to the Covered Person's or the beneficiary's relative by blood or connection by marriage who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

**Physical Examinations:** We, at Our own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

**Legal Action:** No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**Misstatement of Age:** If a Covered Person's age has been misstated, the amount payable shall be such as the premium paid for coverage would have purchased at the correct age.

**Policy Cancellation:** After the Policy has been in force for 12 consecutive months, We may cancel this Policy at any time by written notice delivered to the Policyholder, or mailed to its last address as shown on Our records, stating when, not less than 31 days thereafter, such cancellation shall be effective; and the Policyholder may cancel this Policy at any time by written notice delivered or mailed to Us, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro-rata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on a prorated basis the earned premium which has not been paid. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

We may cancel or offer to modify the Policy for any reason, including the Policyholder's failure to perform any of its obligations that relate to the Policy; the Policyholder does not provide Us with information that We need to administer the Policy.

**Discretionary Authority:** When making a benefit determination under the Policy, We have discretionary authority to determine eligibility, if applicable, for benefits and to interpret the terms and provisions of the Policy. This provision does not prevent the bringing of a legal action under the Legal Action provision, nor does it serve to deprive any insurance department of its statutory rights and obligations.

## GENERAL PROVISIONS (continued)

**Fraud:** We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if a Covered Person or the Policyholder knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

**Incontestability:** We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

**Termination of a Policyholder's Insurance:** Insurance under the Policy will terminate on the earliest of the following dates:

1. on the Premium Due Date of any premium which remains unpaid at the end of the Grace Period.
2. the date the Policyholder terminates its participation under the Policy. The Policyholder must give 31 days advance written notice to Us.
3. the date on which the Policyholder fails to comply with or intentionally makes material misrepresentation relating to the Policy.

We reserve the right to terminate insurance under the Policy on the date that the number of Covered Persons insured under the Policyholder decreases to less than:

1. 75% of all eligible Members of a Policyholder, if the Policyholder contributes partially towards the cost of insurance;
2. 100% of all eligible Members of a Policyholder, if the Policyholder contributes in whole towards the cost of insurance; or
3. 2 Covered Persons.

## COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

**Covered Person's Eligibility:** Members who work on a full-time basis for the Employer are eligible for insurance after completion of the required Member Waiting Period, provided they are in a class of Members who are included. Members will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

A Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Member Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Member's class; or
4. the date the Member enters a class eligible for insurance.

**Effective Date of Covered Person Insurance:** If a Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Member's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

A Employee must use forms provided by Us when applying for insurance.

The Member's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Member becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Member makes application within 31 days after the date he first became eligible, on the later of:
  - a. the date the Member is eligible for insurance, regardless of when he applies; or
  - b. the date the Member's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if a Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class, except if he was in "off-payroll" status for a period of less than 6 months.

**Termination of Covered Person Insurance:** The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the last day of the month during which he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the last day of the month during which he ceases to be Actively at Work, unless
  - a. Active work ceases during an approved medical leave of absence, the Accidental Death and Dismemberment Benefit will continue for up to 3 months from the date he stopped active work.
  - b. A Member is "off-payroll" due to suspension of duties, the Accidental Death and Dismemberment Benefit will continue for up to 12 months from the date he stopped active work.

**COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS  
(continued)**

- c. A Member is “off-payroll” due to any leave of absence, the Accidental Death and Dismemberment Benefit will continue until the end of the leave.

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON

If the Covered Person suffers a loss described below, We will pay the amount of insurance that applies. The Covered Person, or the Covered Person's beneficiary, must give Us proof that:

1. injury occurred while the insurance was in force under this section;
2. loss occurred within 90 days after the injury; and
3. loss was due to injury independent of all other causes.

**Amount of Insurance:** The amount of insurance shown in the Schedule of Benefits will be paid according to the following table:

Loss of life	100%
Loss of both hands or both feet	100%
Loss of sight of both eyes	100%
Loss of one hand and sight of one eye	100%
Loss of one foot and sight of one eye	100%
Loss of one hand	50%
Loss of one foot	50%
Loss of sight of one eye	50%

Loss of sight means total and irrecoverable loss of sight. Loss of hands or feet means severance at or above the wrist or ankle.

In paying this benefit, We will consider only losses sustained while insured under this section of the Policy. We will pay no more than the full amount shown in the Schedule of Benefits for losses resulting from any one injury.

**Limitations:** We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or medical or surgical treatment of these;
2. suicide or intentionally self-inflicted injury, while sane or insane;
3. participation in a riot or insurrection, or commission of an assault or felony;
4. war or any act of war, declared or undeclared;
5. use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;
6. driving while intoxicated, as defined by the applicable state law where the loss occurred;
7. injury arising out of or in the course of any occupation or employment for pay or profit, or any injury or sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule of Benefits;

**Assignment:** Accidental Death and Dismemberment insurance provided by the Policy cannot be assigned.

## **California Consumer Complaint Notice**

If you have any questions or problems with your coverage, We will be ready to help you. Our contact information is:

**Unimerica Life Insurance Company  
A Stock Company**

**Administrative Offices: 6300 Olson Memorial Highway, Golden Valley, MN 55427  
1-866-615-8727**

You may also call the California Department of Insurance for assistance. However, We ask that you give Us the opportunity to try to resolve your problem. Please, call us first. If, We fail to help you, you may still ask the California Department of Insurance for assistance. Their contact information is:

**California Department of Insurance  
Consumer Services Division  
300 South Spring Street  
Los Angeles, California 900013  
1-800-927-HELP  
(1-800-927-4357)**



## STATUTORY PROVISIONS

### ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

#### **Insurer Information Notice**

Any questions regarding the Policy may be directed to:  
Unimerica Life Insurance Company  
Administrative Offices  
6300 Olson Memorial Highway  
Golden Valley, MN 55427  
1-866-615-8727

If the question is not resolved, you may contact the Arkansas Insurance Department:  
Arkansas Insurance Department  
Consumer Services Division  
400 University Tower Building  
Little Rock, Arkansas 77204  
Telephone: 1-800-852-5494

### IDAHO

Residents of the state of Idaho, the following provision is included to bring your Certificate into conformity with Idaho state law:

#### **Incontestability**

The Incontestability provision as contained in the section entitled CERTIFICATE GENERAL PROVISIONS is hereby changed to read as follows:

**Incontestability:** We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for one year from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of one year during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

### MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non-Minnesota situated Employers have 25 or more Members residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits  
Contract Services  
MN010-W115  
6300 Olson Memorial Highway  
Golden Valley, MN 55427

### MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

**Conformity with Montana Statutes:** For Montana residents, the provisions of this Policy are intended to conform to the minimum requirements of Montana law. If any provision of the Policy conflicts with any Montana statutes, the provision will be deemed to conform to the minimum requirements of the Montana law.

## **MONTANA (continued)**

### **Discretionary Authority**

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section it is hereby deleted in its entirety.

## **NEW HAMPSHIRE**

Residents of the state of New Hampshire, the following provision is included to bring your Certificate into conformity with New Hampshire state law:

### **Proof of Claim**

The provision(s) entitled Proof of Claim as contained in the Certificate of Coverage is modified to include the following:

Failure to furnish such proof of claim within the Certificate of Coverage stated time limit will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as it was reasonably possible.

### **Discretionary Authority**

When a Discretionary Authority provision is shown in the Certificate of Coverage GENERAL PROVISIONS section it is hereby deleted in its entirety.

## **NORTH CAROLINA**

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

### **Proof of Claim**

The provision(s) entitled Proof of Claim as contained in the Certificate is modified as follows:

Written proof of claim must be filed within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

### **Occupational Injury or Sickness Exclusion**

Any exclusion that applies to an Occupational Injury or Sickness is hereby replaced by the following:

An Occupational Injury or Sickness for treatments which are paid under the North Carolina Worker's Compensation Act only to extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

## **NORTH DAKOTA**

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

**10 Day Right to Examine Certificate:** There is a 10 day right to review this Certificate. If You decide not to keep it, it may be returned to Us within 10 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all premium paid. Any claims paid during the initial 10 day period will be deducted from the refund.

## OKLAHOMA

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

**Certificates delivered to residents of state of Oklahoma are subject to Oklahoma laws.**

### **Incontestability**

The Incontestability provision shown in the Certificate GENERAL PROVISIONS section is replaced by the following:

**Incontestability:** We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

**Payment of Claim:** Payment of Claim for loss of life will be paid in accordance with the beneficiary section. We will make payment within 60 days of receipt of due proof of death. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

## TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

### **IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call Unimerica Life Insurance Company's toll-free telephone number for information or to make a complaint at

800-554-5413

You may also write to Unimerica Life Insurance Company at:

Unimerica Life Insurance Company  
Administrative Offices  
6300 Olson Memorial Highway  
Golden Valley, MN 55427

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104  
Austin, TX 78714-9104

### **AVISO IMPORTANTE**

Para obtener información or para someter una queja:

Usted puede llamar al numero de telefono gratis de Unimerica Life Insurance Company 's para información o para someter una queja al

800-554-5413

Usted también puede escribir a Unimerica Life Insurance Company's:

Unimerica Life Insurance Company  
Administrative Offices  
6300 Olson Memorial Highway  
Golden Valley, MN 55427

Puede comunicarse con el Departamento de Seguro de Texas para obtener informacion acerca de compañías, coberturas, derechos o quejas al 800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104

FAX #(512) 475-1771

Austin, TX 78714-9104  
FAX #(512)475-1771

**PREMIUM OR CLAIM DISPUTES:**

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

**DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**ATTACH THIS NOTICE TO YOUR POLICY:**

This notice is for information only and does not become a part or condition of the attached document.

**ADJUNTAR ESTE AVISO A SU POLIZA:**

Esto aviso es solo para proposito de informacion y no se convierte en parte o condición del documento adjunto.

Form No. ACN-TX-MP (8/95)

**Incontestability**

The Incontestability provision under the CERTIFICATE GENERAL PROVISIONS section, is amended to remove the phrase "or fraudulent misrepresentations" from the first sentence.

**WASHINGTON**

**Accidental Death and Dismemberment Benefit**

The first paragraph shown in the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON section is replaced by the following:

The Covered Person suffers a loss described below, We will pay the amount of insurance that applies. The Covered Person, or the Covered Person's beneficiary, must give Us proof that:

1. Injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the Injury; and
3. loss was due to Injury independent of all other causes.

## STATUTORY PROVISIONS

### ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

#### **Insurer Information Notice**

Any questions regarding the Policy may be directed to:  
Unimerica Life Insurance Company  
Administrative Offices  
6300 Olson Memorial Highway  
Golden Valley, MN 55427  
1-866-615-8727

If the question is not resolved, you may contact the Arkansas Insurance Department:  
Arkansas Insurance Department  
Consumer Services Division  
400 University Tower Building  
Little Rock, Arkansas 77204  
Telephone: 1-800-852-5494

### MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non-Minnesota situated Employers have 25 or more Employees residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits  
Contract Services  
MN010-W115  
6300 Olson Memorial Highway  
Golden Valley, MN 55427

### MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

**Conformity with Montana Statutes:** For Montana residents, the provisions of this Policy are intended to conform to the minimum requirements of Montana law. If any provision of the Policy conflicts with any Montana statutes, the provision will be deemed to conform to the minimum requirements of the Montana law.

#### **Discretionary Authority**

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section it is hereby deleted in its entirety.

#### **Disability Pre-Existing Exclusion**

Any applicable Pre-Existing exclusion will not be applied to any disability that begins more than 12 months after the Covered Person's Effective Date of insurance.

## NEW HAMPSHIRE

Residents of the state of New Hampshire, the following provision is included to bring your Certificate into conformity with New Hampshire state law:

### Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate of Coverage is modified to include the following:

Failure to furnish such proof of claim within the Certificate of Coverage stated time limit will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as it was reasonably possible.

### Discretionary Authority

When a Discretionary Authority provision is shown in the Certificate of Coverage GENERAL PROVISIONS section it is hereby deleted in its entirety.

## NORTH CAROLINA

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

### Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate is modified as follows:

Written proof of claim must be filed within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

### Occupational Injury or Sickness Exclusion

Any exclusion that applies to an Occupational Injury or Sickness is hereby replaced by the following:

An Occupational Injury or Sickness for treatments which are paid under the North Carolina Worker's Compensation Act only to extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

## NORTH DAKOTA

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

**10 Day Right to Examine Certificate:** There is a 10 day right to review this Certificate. If You decide not to keep it, it may be returned to Us within 10 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all premium paid. Any claims paid during the initial 10 day period will be deducted from the refund.

## OKLAHOMA

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

**Certificates delivered to residents of state of Oklahoma are subject to Oklahoma laws.**

## **OKLAHOMA (continued)**

### **Incontestability**

The Incontestability provision shown in the Certificate GENERAL PROVISIONS section is replaced by the following:

**Incontestability:** We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

## **TEXAS**

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

### **Incontestability**

The Incontestability provision under the CERTIFICATE GENERAL PROVISIONS section, is amended to remove the phrase "or fraudulent misrepresentations" from the first sentence.

## TEXAS

### IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Unimerica Life Insurance Company's toll-free telephone number for information or to make a complaint at

800-554-5413

You may also write to Unimerica Life Insurance Company at:

Unimerica Life Insurance Company  
Administrative Offices  
6300 Olson Memorial Highway  
Golden Valley, MN 55427

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104  
Austin, TX 78714-9104  
FAX #(512) 475-1771

#### PREMIUM OR CLAIM DISPUTES:

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

#### ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

### AVISO IMPORTANTE

Para obtener información or para someter una queja:

Usted puede llamar al numero de telefono gratis de Unimerica Life Insurance Company's para información o para someter una queja al

800-554-5413

Usted también puede escribir a Unimerica Life Insurance Company's:

Unimerica Life Insurance Company  
Administrative Offices  
6300 Olson Memorial Highway  
Golden Valley, MN 55427

Puede comunicarse con el Departamento de Seguro de Texas para obtener informacion acerca de compañías, coberturas, derechos o quejas al 800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104  
Austin, TX 78714-9104  
FAX #(512)475-1771

#### DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

#### ADJUNTAR ESTE AVISO A SU POLIZA:

Esto aviso es solo para proposito de informacion y no se convierte en parte o condición del documento adjunto.

Form No. ACN-TX-MP (8/95)



# Unimerica Life Insurance Company

## Notice of Privacy Policy and Practices

### **Purpose of this Notice**

Unimerica Life Insurance Company respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the personal information we receive. Our practices apply to current and former members.

### **Types of Personal Information We Collect**

We collect a variety of personal information to administer a member's life or health coverage. Some of this information is provided by members in enrollment forms, surveys and correspondence (such as address, Social Security number, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions with our affiliates and members, employers, insurance agents, other insurers, and health care providers. We retain this information after a member's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

### **How We Protect Personal Information**

We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide our products or services to members (for example, our claims processors and care coordinators). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

### **Disclosure of Personal Information**

We may share any of the personal information we collect (as described above) with our affiliates as permitted by law. We may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a member's authorized representative, health care providers, third party administrators, insurance agents and brokers, other insurers, consumer reporting agencies, and law enforcement or regulatory authorities. We may also disclose any of the personal information we collect (as described above) to companies that perform marketing services on our behalf or to other companies with whom we have joint marketing or disease management agreements. We do not disclose personal information to any other third parties without a member's request or authorization.

### **Individual Rights to Access and Correct Personal Information**

We have procedures for a member to access the personal information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the member upon written request. Our goal is to keep our member information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal information we have about you is not accurate, please let us know by contacting our Compliance Officer at UnitedHealthcare Specialty Benefits, Mail Route MN010-W115, 6300 Olson Memorial Highway, Golden Valley, MN 55427.

### **Further Information**

We may amend our privacy policy from time to time. In accordance with applicable law, we will send our current customers a Notice describing our privacy policy and practices at least once a year. It will also be available upon request. This Notice is provided on behalf of the following Unimerica Life Insurance Company affiliates:

For purposes of this Notice of Privacy Practices, “we” or “us” refers to the following United HealthCare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Eyecare of North Carolina, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; United HealthCare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; United HealthCare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; United HealthCare of New England, Inc.; United HealthCare of New Jersey, Inc.; United HealthCare of New York, Inc.; United HealthCare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; United HealthCare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.