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# YOUR GROUP TERM LIFE BENEFITS

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**FOR MEMBERS OF:**

**California Association of Professional Employees**

**CLASS(ES):**

All Eligible Members

**EFFECTIVE DATE:**

July 1, 2019

**PUBLICATION DATE:**

June 27, 2019

**NOTICE(S)**

**THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF CALIFORNIA.**

**IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.**

**FRAUD WARNING**

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Group Number: G000BKC6

## NOTICE

If a problem occurs, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, Nebraska 68175  
Call Toll-Free: 1-800-775-8805  
[www.mutualofomaha.com](http://www.mutualofomaha.com)

The Department of Insurance should be contacted only after the contacts between You and the Policyholder or Your benefits administrator and Your insurance company or its representatives have failed to produce a satisfactory solution to the problem. To contact the Department of Insurance, write or call:

Consumer Division  
Department of Insurance, Los Angeles Office  
300 South Spring Street  
Los Angeles, California 90013  
1-800-927-4357  
<http://www.insurance.ca.gov/01-consumers/>

## **ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)**

### **LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) WILL BE REDUCED IF BENEFITS ARE PAID UNDER THE LIVING BENEFITS (ACCELERATED BENEFIT) PROVISION.**

This disclosure is a brief summary of the Living Benefits (Accelerated Benefit) provision and its effect on life insurance benefits.

An eligible Insured Person may receive payment of part of the amount of life insurance in effect for the Insured Person while living if the Insured Person has been diagnosed with a terminal condition. A terminal condition means an injury or sickness that is expected to result in death within the number of months stated in the Certificate, as certified by a Physician. Please refer to the Living Benefits (Accelerated Benefit) provision of this Certificate for information regarding who is eligible for this benefit and the complete definition of Terminal Condition.

This benefit is included in the premium paid for life insurance. There is no separate premium charge for this benefit. The premium for life insurance does not change if benefits are paid under the Living Benefits (Accelerated Benefit) provision.

The Living Benefits offered under this contract **may or may not** qualify for favorable tax treatment under the Internal Revenue Code of 1986 (as amended). Whether such benefits qualify depends on factors such as the life expectancy of You at the time benefits are accelerated or whether You use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Living Benefits qualify for favorable tax treatment, the benefits will be excludable from Your income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive Living Benefits excludable from income under federal law.

Receipt of Living Benefits may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect Your, Your Spouse's or Your family's eligibility for public assistance.

**The Living Benefits (Accelerated Benefit) provision will end with the termination of this Policy.**

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# CERTIFICATE OF INSURANCE

## UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:  
Mutual of Omaha Plaza  
Omaha, Nebraska 68175

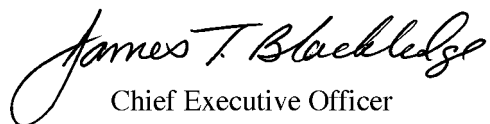
United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-BKC6 (the Policy) has been issued to California Association of Professional Employees (the Policyholder).

Insurance is provided for Members of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

  
Chief Executive Officer

  
Corporate Secretary

## SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

### CLASS(ES)

All Eligible Members

### LIFE INSURANCE FOR YOU (THE MEMBER)

Your amount of life insurance is \$30,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

### EVIDENCE OF INSURABILITY

Evidence of Insurability is not required for any amount of insurance under the Policy, unless otherwise stated in this Certificate.

### BENEFIT REDUCTIONS

As You grow older, the amount of life insurance for You will be reduced according to the following schedule:

<b>At the Age of:</b>	<b>The Original Amount of Insurance Will Reduce to:</b>
70 .....	50%

Reductions become effective on the first day of the Policy month that coincides with or follows the day You reach the specified age. Any reduced amount of insurance will round to the nearest dollar.

If You are age 70 or older on the date insurance becomes effective, the amount of life insurance for You will be reduced as shown above.



## ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

### DEFINITIONS

*Actively Eligible, Active Eligibility* means a Member is:

- a) eligible for insurance according to the Policyholder's rules of eligibility as approved by Our authorized representative in Our home office;
- b) is not Totally Disabled; and
- c) eligible for insurance under the Policy in accordance with the terms and conditions of this Eligibility section.

If the Policyholder's rules of eligibility for insurance conflict with any of the terms and conditions of this Eligibility section, the terms and conditions of this Eligibility section shall control. Any changes to the Policyholder's rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance under the Policy unless such changes have been approved by Our authorized representative in Our home office.

*Disability Elimination Period* means the period of time that must be satisfied before You are eligible to continue benefits, beginning on the date Your Injury or Sickness occurred. The length of the disability elimination period is shown in the Continuation of Insurance for Total Disability with Waiver of Premium provision.

*Partial Disability, Partially Disabled* means that, because of a disability that renders You unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your usual occupation in the usual or customary way lasting longer than 12 months, You are unable to perform the normal duties of Your regular job for the Policyholder on a regular or continuous basis, but are still able to satisfy the requirements of the Member definition.

*Recurrent Disability* means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

*Total Disability, Totally Disabled* means that because of an Injury or Sickness You are unable to perform with reasonable continuity the substantial and material duties of Your occupation during the first 24 months following the date Your Injury or Sickness occurred. After 24 months of Total Disability, you are unable to engage with reasonable continuity in another occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, physical and mental capacity.

### WHEN A MEMBER BECOMES ELIGIBLE FOR INSURANCE

A Member who is Actively Eligible on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An individual that becomes a Member after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Member begins Active Eligibility.

The day on which a Member becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

### CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for a Member who:

- a) was insured under the Prior Plan on the day before the Policy Effective Date;
- b) is otherwise eligible under the Policy, but is not Actively Eligible on the Policy Effective Date due to:
  1. Injury or Sickness; or

2. a leave of absence protected under:
  - a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
  - b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
- c) is not eligible for benefits or continuation of insurance under any provision of the Prior Plan;
- d) is not a retired Member; and
- e) is not Totally Disabled on the Policy Effective Date.

Insurance under this provision is subject to the following conditions:

- a) insurance under the Policy may not exceed Your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
- b) the benefit payable under the Policy will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
- c) the Policyholder must notify Us in writing prior to the Policy Effective Date of the amount of Your insurance under the Prior Plan on the day before the Policy Effective Date;
- d) insurance is subject to uninterrupted payment of premium to Us when due; and
- e) insurance is subject to any reductions shown in the Schedule and all other terms and conditions of the Policy.

We reserve the right to request any information We need about the Prior Plan from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

- a) the day the Member returns to Active Eligibility for the Policyholder or begins employment with any other employer;
- b) the last day the Member would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
- c) the day the Member's insurance under the Policy ends for any reason shown in the When Insurance Ends provision;  
or
- d) the last day of the twelfth month following the Policy Effective Date.

If a Member is eligible for insurance under this provision, the Member will not be eligible for insurance under any continuation provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Eligibility, You may be able to obtain insurance under the Conversion provision.

Persons who are not eligible for insurance under this provision may be eligible to apply for conversion of insurance under the Prior Plan and should contact the Policyholder for additional information.

## **WHEN INSURANCE BEGINS**

An eligible Member will become insured on the latest of the day:

- a) the Member begins Active Eligibility; or
- b) the Member submits a Written Request to enroll for insurance, if applicable.

If the Member is not Actively Eligible on the day insurance would otherwise begin, insurance will begin on the day the Member returns to Active Eligibility.

## **EXCEPTIONS TO WHEN INSURANCE BEGINS**

This provision does not apply if the Member is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for a Member or Dependent who is:

- a) Totally Disabled;
- b) confined in a Hospital as an inpatient;

- c) confined in any institution or facility other than a Hospital such as a skilled nursing facility, convalescent nursing home, extended care facility or residential care facility; or
  - d) confined at home and under the care or supervision of a Physician;
- on the day insurance is to begin will not take effect until the day after the Member or Dependent is no longer confined or the Member is no longer Totally Disabled.

In addition, insurance for a Member who is unable to perform the usual and customary duties and activities of a healthy individual of the same age and gender will not take effect until the day the Member is able to consistently perform such duties and activities.

## **CHANGES TO INSURANCE BENEFITS**

Any allowable change in Your class or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the date of the request or the change.

For any increase in insurance, We will use the Policyholder's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Eligible on the day any increase in insurance would otherwise take effect, the increase will become effective the day after You return to Active Eligibility.

## **REINSTATEMENT OF INSURANCE**

You may be eligible to reinstate insurance that has ended in accordance with this provision.

Reinstated insurance will take effect on the date You become eligible for insurance. If You are not Actively Eligible on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Eligibility.

The following reinstatement option(s) is/are available:

### **Transfer From Conversion**

If insurance was obtained under the Conversion provision while a Member was not Actively Eligible, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Eligibility.

## **WHEN INSURANCE ENDS**

Insurance will end on the last day of the month in which the earliest of the following events occurs:

- a) an Insured Person is no longer eligible for insurance under the Policy; or
- b) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less).

Insurance will also end:

- a) on the day the Policy terminates; or
- b) in accordance with the Grace Period provision.

## **NOTICE TO YOU WHEN INSURANCE ENDS**

The Policyholder is required to notify You when insurance under the Policy ends if:

- a) You cease to be eligible for insurance under the Policy; or
- b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You, and shall include information about any options available to continue or obtain insurance.

## **EXCEPTIONS TO WHEN INSURANCE ENDS**

If insurance for You would otherwise end, You may be able to continue or obtain insurance under one of the following provisions:

- a) Continuation of Insurance for Layoff or Leave
- b) Continuation of Insurance for Injury or Sickness
- c) Continuation of Insurance for Partial Disability
- d) Continuation of Insurance for Total Disability with Waiver of Premium
- e) Conversion

## **CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE**

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance from the day You cease to be Actively Eligible in the event of:

- a) a temporary involuntary layoff; or
- b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision will be subject to the following conditions:

- a) insurance may not be continued beyond the earliest of:
  1. 12 weeks for Your temporary involuntary layoff;
  2. 12 weeks for Your leave of absence; or
  3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
- b) the amount of insurance may not be increased while insurance is continued under this provision; and
- c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the last day of the month which coincides with or follows the earliest of the day:

- a) the time period in a) in the preceding paragraph has been satisfied;
- b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
- c) You return to Active Eligibility;
- d) You begin full-time employment with an employer other than the Policyholder; or
- e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Eligibility, You may be able to continue or obtain insurance under the Continuation of Insurance for Injury or Sickness provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

## **CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS**

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance would otherwise end due to Your Injury or Sickness, You may be able to continue insurance under this provision. In such circumstances, the total continuation period under this provision and the Continuation of Insurance for Layoff or Leave provision, if You were previously insured under this provision, shall not exceed 12 months.

Insurance may be continued under this provision if We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

- a) that is 12 months from the day You cease Active Eligibility;
- b) You return to Active Eligibility;
- c) You begin full-time employment with an employer other than the Policyholder; or
- d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Eligibility, You may be able to continue or obtain insurance under the Continuation of Insurance for Partial Disability provision, Continuation of Insurance for Total Disability with Waiver of Premium provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

## **CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY**

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision, You may be able to continue insurance under this provision due to Your Partial Disability.

Insurance may be continued under this provision if the following conditions are satisfied:

- a) You are Partially Disabled, but not Totally Disabled; and
- b) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

- a) You return to Active Eligibility;
- b) Your Injury or Sickness results in Your Total Disability and You are eligible to continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
- c) You begin full-time employment with an employer other than the Policyholder; or
- d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If Your insurance under this provision ends and You have not returned to Active Eligibility, You may be able to obtain insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision or Conversion provision.

If Your Partial Disability may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

## **CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM**

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance ends under the Continuation of Insurance for Injury or Sickness provision or Continuation of Insurance for Partial Disability provision, You may be able to continue insurance under this provision due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability, Your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

- a) You are Totally Disabled;
- b) You were under age 60 at the time You became Totally Disabled;
- c) the Disability Elimination Period is satisfied; and
- d) proof of Total Disability is provided to Us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

If You are age 60 or older and become Totally Disabled, You may be able to obtain insurance under the Conversion provision.

### **About the Disability Elimination Period**

The Disability Elimination Period is a period of 9 consecutive months. Any period of time in which You are insured under the Continuation of Insurance for Injury or Sickness provision will apply toward satisfaction of the Disability Elimination Period.

### **Proof of Total Disability**

You must submit to Us proof of Total Disability approved by Our authorized representative in Our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter. Proof of Total Disability may include medical records, a physical examination and a Physician statement.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense.

If You are approved for continuation of insurance under this provision, We will periodically require proof of continuing Total Disability. We may have You examined by a Physician of Our choice at any time during the first two years of Total Disability and once a year thereafter at Our expense. If an additional examination is requested by You because You question or dispute the results of the examination by the Physician of Our choice, any additional examination may be at Your expense.

### **When Continuation of Insurance for Total Disability is Approved**

We will notify You in writing if Your proof of Total Disability is approved by Us. Any premium paid for Your insurance from the day You ceased to be Actively Eligible will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Disability Elimination Period if:

- a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
- b) Your Recurrent Disability occurs within 6 months of the end of Your prior claim.

### **When Continuation of Insurance for Total Disability is Not Approved**

We will notify You in writing if Your proof of Total Disability is not approved by Us. If at any time while You are insured under this provision We determine that You are no longer Totally Disabled, We will notify You in writing that You are no longer eligible to continue insurance under this provision.

If You are ineligible for insurance under this provision or Your insurance under this provision ends, You will have 31 days from the date of Our notice to submit a Written Request for insurance under the Conversion provision, if You have not

returned to Active Eligibility or You are not eligible for insurance under the Continuation of Insurance for Partial Disability provision.

### **When Insurance Under this Provision Ends**

Insurance under this provision will end on the last day of the month which coincides with or follows the day:

- a) You are eligible to continue insurance under the Continuation of Insurance for Partial Disability provision; or
- b) You return to Active Eligibility.

Insurance under this provision will also end on the earliest of the day:

- a) You are no longer Totally Disabled;
- b) that is 90 days after the date of Our request to You for proof of Total Disability if such proof has not been received by Us;
- c) You fail to obtain an examination from a Physician of Our choice as described in the Proof of Total Disability provision by a date established by Us;
- d) You reach age 65; or
- e) You begin full-time employment with an employer other than the Policyholder.

Insurance under this provision will also end in accordance with the Grace Period provision.

### **CONVERSION**

This provision allows for conversion of life insurance.

#### **When Employment or Class Membership Ends or the Amount of Insurance Reduces**

If group life insurance ends because Your employment or membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance ("Conversion Policy").

The Conversion Policy issued under this provision will be:

- a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; and
- b) issued without any supplemental benefits.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

#### **When the Policy or a Class Terminates**

You may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:

- a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
- b) issued without any supplemental benefits;
- c) for an amount of life insurance that does not exceed the lesser of:
  1. \$10,000; or
  2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

**Notice of the Right to Obtain Insurance Under this Provision**

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces (“Conversion Period”). When insurance ends under the Policy, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:

- a) 15 days after notice has been received; or
- b) 60 days after the end of the Conversion Period, even if notice is not received.

If You are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You did not apply for a Conversion Policy.

**How to Request Insurance Under this Provision**

Insurance is available without providing Evidence of Insurability. You must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

**Conversion Insurance and Your Return to Active Eligibility**

If You are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.



## **PREMIUM PAYMENTS**

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

### **OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE**

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

- a) the Policyholder may pay the premiums; or
- b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

### **GRACE PERIOD**

All premiums must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

### **PREMIUM CHANGES**

If You request a change in the amount of insurance, the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance in accordance with the terms of the Policy, or a change in the amount of insurance as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

- a) You reach an age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
- b) premium rates under the Policy are changed.

## **LIFE INSURANCE BENEFITS**

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

### **BENEFITS**

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You. Benefits payable by reason of Your death will be paid to Your beneficiary.

### **BENEFICIARY DESIGNATION**

At the time You elect(ed) insurance under the Policy or any Prior Plan, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

- a) Your surviving Spouse; if none, then to
- b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
- c) Your surviving parent(s), in equal shares; if none, then to
- d) Your estate.

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

### **BENEFICIARY CHANGE**

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then You may send the Written Request to Us. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

### **FACILITY OF PAYMENT**

We may pay an amount of up to \$500 to any person or entity that has incurred expenses related to Your death and subsequent burial. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

## **LIVING BENEFITS (ACCELERATED BENEFIT)**

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

**The benefits received under this section may be taxable. Receipt of Living Benefits may adversely affect eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting Living Benefits.**

### **DEFINITIONS**

*Living Benefits* means an advance payment of part of Your life insurance death benefit.

*Terminal Condition* means an Injury or Sickness that is expected to result in Your death within the next 12 months as certified by an attending Physician's written statement.

### **ABOUT LIVING BENEFITS**

If You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for Living Benefits.

The maximum amount of Living Benefits available is 75% of the amount of life insurance for You in effect at the time of the request or \$22,500, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for You at the time of the request or \$1,000, whichever is greater.

We will pay Living Benefits to You in a lump sum, provided You are living at the time payment is made.

The amount of life insurance benefits payable for You in the event of death will be reduced by the amount of Living Benefits paid for You.

### **APPLYING FOR LIVING BENEFITS**

To apply for Living Benefits, You, Your Spouse or Your legal representative must provide Us:

- a) a Written Request for Living Benefits;
- b) satisfactory proof of Your Terminal Condition, which may include an attending Physician's written statement, medical records and a physical examination; and
- c) a statement of consent from any beneficiary(ies) or assignee(s).

You, Your Spouse or Your legal representative will receive information at the time of benefit payment about the amount of life insurance remaining in force after payment of Living Benefits.

### **CONDITIONS OF LIVING BENEFITS**

Living Benefits are subject to the following conditions:

- a) Living Benefits are payable for You only once under the Policy;
- b) You can request Living Benefits in any \$1,000 increment, subject to the limits specified in this section;
- c) Premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the Continuation of Insurance for Total Disability with Waiver of Premium provision; and
- d) The amount of insurance You may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You.

### **WHEN LIVING BENEFITS ARE NOT AVAILABLE**

Living Benefits are not available:

- a) when You have irrevocably assigned life insurance under the Policy;
- b) if such benefits were paid under a Prior Plan;
- c) when all or a portion of the life insurance benefits under the Policy are to be paid to a former Spouse as part of a divorce agreement or pursuant to a court order;
- d) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
- e) during any Conversion Period;
- f) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
- g) if requested after insurance under the Policy ends; or
- h) if requested after the Policy terminates.

## **PAYMENT OF CLAIMS**

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

### **NOTICE OF CLAIM AND CLAIMS FORMS**

Before benefits are paid, We must be given written proof of claim as described in the Proof of Loss section below.

Notice of claim may be made to Us (or any of Our authorized agents) within 20 days, or as soon as reasonably possible, after a death and/or a loss under the Accidental Death and Dismemberment Benefits Rider occurs. The notice should include:

- a) The Policyholder's name and the Policy number or group number.
- b) The Insured Person's name and mailing address.
- c) Your name, mailing address and relationship to the Insured Person, if You are not the Insured Person for whom the claim is being filed.
- d) The Claimant's name and mailing address, if the Claimant is other than You or the Insured Person

Failure to give notice within this time frame shall not invalidate nor reduce any claim.

Upon receipt of notice of claim, We will furnish to You, the Insured Person, or the beneficiary such forms as We usually furnish for filing a proof of occurrence or proof of loss. A claim form can also be obtained at any time through Our website.

If We do not provide the requested or necessary form(s) within 15 days after giving notice, the claimant shall be deemed to have complied with the requirements of the provision by providing, within the time frame for submitting proof of loss, written proof of claim that includes the nature, date, cause and extent of the loss for which the claim is made, in addition to the information listed previously in this section.

### **HOW TO OBTAIN PLAN BENEFITS**

Forward the completed claim form to:  
Benefits Administrator  
California Association of Professional Employees  
3018 E Colorado Blvd  
200  
Pasadena, California 91107

### **CLAIM ASSISTANCE**

For assistance with filing a claim or an explanation of how a claim was paid, contact:  
United of Omaha Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, Nebraska 68175  
Call Toll-Free: 1-800-775-8805

### **PROOF OF LOSS**

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

- a) it was not reasonably possible to give proof within that 90-day period; and
- b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

## **PHYSICAL EXAMINATION**

We may occasionally require the person of the insured to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations.

## **PAYMENT OF CLAIMS**

Benefits will be paid after We receive written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section.

The following statement is required by California law: Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of written proof of loss.

## **MODE OF PAYMENT**

Life insurance benefits will be available in one lump sum.

## **REFUND TO US**

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to recover any payments due to:

- a) fraud or misrepresentation; or
- b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

## CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

**IMPORTANT NOTICE:** In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If you have any questions, please contact Us.

### DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

*Adverse Benefit Determination* means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

*Claimant* means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

### CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

### INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

- a) Initial claim decision period: 90 days
- b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

### CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

- a) the specific reason(s) for the denial;
- b) reference to the specific Policy provisions on which the denial is based;
- c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
- d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

## **OPPORTUNITY TO REQUEST AN APPEAL**

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

- a) the Insured Person's name;
- b) the name of the person filing the appeal if different from the Claimant;
- c) the Policy number; and
- d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

## **RESPONSE TO APPEALS**

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

- a) information regarding the decision; and
- b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.



## **CLAIM REVIEW AND APPEAL PROCEDURES FOR CONTINUATION OF INSURANCE FOR TOTAL DISABILITY BENEFITS**

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

### **DEFINITIONS**

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

*Adverse Benefit Determination* means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, and such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

*Claimant* means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

### **CLAIM REVIEW PROCEDURES**

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

### **INITIAL CLAIM DECISION**

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

- a) initial claim decision period: 45 days unless additional information is requested as set forth below;
- b) extension period: 30 days; and
- c) maximum number of extensions: two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

### **CLAIM DENIALS**

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

- a) the specific reason(s) for the denial;
- b) reference to the specific Policy provisions on which the denial is based;
- c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
- d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

## **OPPORTUNITY TO REQUEST AN APPEAL**

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

- a) the Claimant's name;
- b) the name of the person filing the appeal if different from the Claimant;
- c) the Policy number; and
- d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

- a) was relied upon in making the claim decision;
- b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
- c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

## **RESPONSE TO APPEALS**

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

- a) information regarding the decision; and
- b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

## STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

### INSURANCE CONTRACT

The insurance contract consists of:

- a) the Policy;
- b) the Policyholder's signed application attached to the Policy; and
- c) any signed application for You.

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application, unless contained in a written application, to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary with a copy of that application.

### CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

- a) does not require the consent of any Insured Person or beneficiary; and
- b) must be:
  1. in writing;
  2. made a part of the Policy; and
  3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

### INCONTESTABILITY

We will not contest this Certificate after it has been in force during Your lifetime for two years from its effective date. Any contest may only be based on a statement made in an application for this Certificate and only if such application is attached to this Certificate. The statement(s) upon which any contest may be based must be material to the risk We assumed.

### LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

## GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

*Certificate* means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

*Evidence of Insurability* means proof of good health approved by Us. This proof may be obtained through health applications, questionnaires, physical exams or written documentation, as required by Us.

*Hospital* means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

*Injury, Injuries* means an accidental bodily injury that requires treatment by a Physician.

*Member* means a person who is:

- a) a citizen or permanent resident of the United States; or
- b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
- c) receiving compensation from the Policyholder for work performed for the Policyholder at:
  1. the Policyholder's usual place of business;
  2. an alternative work site at the direction of the Policyholder; or
  3. a location to which the employee must travel to perform the job; and

A member does not include a person:

- a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
- b) working on a seasonal or temporary basis; or
- c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

*Our, We, Us* means United of Omaha Life Insurance Company.

*Physician* means any of the following licensed practitioners:

- a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- b) a licensed doctoral clinical psychologist;
- c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
- d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
- e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

- a) a naturopathic doctor;
- b) an acupuncturist;
- c) a physician in training; or
- d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

*Plan Administrator* means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

*Policy* means the group policy issued to the Policyholder by Us, including this Certificate.

*Policy Anniversary* means July 1 of each Policy Year.

*Policy Effective Date* means July 1, 2019.

*Policy Year* means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

*Prior Plan* means any policy or plan of benefits:

- a) replaced by insurance under part or all of the Policy; and
- b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

*Schedule* means the section of the Certificate identified as the "Schedule".

*Sickness* means a disease, disorder or condition that requires treatment by a Physician.

*Spouse* means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by federal law, or by state law in Your state of residence. A spouse may include Your same sex or opposite sex domestic or civil union partner or equivalent if:

- a) You submit to the Policyholder a written declaration of partnership signed by You and Your partner; or
- b) You submit evidence that all applicable requirements of the jurisdiction in which you reside regarding the establishment of a domestic or civil union partnership have been met.

*Written Request* means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content approved by Us.

*You, Your, Insured Person* means the Member who is insured under the Policy.

**Group Term Life Benefits**

**California Association of Professional Employees**

**Group Number: G000BKC6**

**United of Omaha Life Insurance Company**

**Home Office:  
Mutual of Omaha Plaza  
Omaha, Nebraska 68175**



**Mutual of Omaha**