RELIANCE STANDARD
LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois • Administrative Office: Philadelphia, Pennsylvania

POLICYHOLDER: Annandale Public School ISD 0876 **POLICY NUMBER:** GL 682975

EFFECTIVE DATE: January 1, 2014, as amended through November 1, 2018

ANNIVERSARY DATES: January 1, 2015 and each January 1st thereafter.

PREMIUM DUE DATES: The first premium is due on the Effective Date. Further premiums are due monthly, in advance, on the first day of each month.

The Policy is delivered in Minnesota and is governed by its laws.

We agree to provide insurance to you in exchange for the payment of premium and a signed Application. The Policy provides benefits for loss of life from injury or sickness. It insures the eligible persons for the amount of insurance shown on the Schedule of Benefits. All payments will be made by our Administrative Office within two (2) months after receipt of due proof of death. The insurance is subject to the terms and conditions of the Policy.

The effective date of the Policy is shown above. Insurance starts and ends at 12:01 A.M., Local Time, at your main address. It stays in effect as long as premium is paid when due. The "TERMINATION OF THE POLICY" section of the GENERAL PROVISIONS explains when the insurance can be ended.

The Policy is signed by the President and Secretary.

Secretary

President

Countersigned_____
Licensed Resident Agent

GROUP LIFE INSURANCE
NON-PARTICIPATING

This policy is a legal contract between the policyholder and the company. Read your policy carefully.

This Group Life Policy amends the Group Life Policy previously issued to you by us. It is issued on November 1, 2018.

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

GROUP POLICY NUMBER: GL 682975

POLICY EFFECTIVE DATE: January 1, 2014, as amended through November 1, 2018

POLICY DELIVERED IN: Minnesota

ANNIVERSARY DATE: January 1st in each year

Application is made to us by: Annandale Public School ISD 0876

This Application is completed in duplicate, one copy to be attached to your Policy and the other returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Signed at _____ this _____ day of _____

Policyholder: _____ Agent: _____

By: _____ _____
(Signature) (Licensed Resident Agent)

_____
(Title)

Please sign and return.

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

*BC1COAPGL 68297501/01/2019*RSL
*BC2COAPAnnandale Public School ISD 0876

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SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: None

ELIGIBLE CLASSES: Each person, except any person employed on a temporary or seasonal basis, according to the following classifications:

CLASS 1: Active, Full-time Superintendent

CLASS 2: Active, Full-time Administration Employee, Principal or Community Education Director

CLASS 3: Active, Full-time Non-Certified Staff excluding Food Service Employee

CLASS 4: Active, Full-time Head Custodian

CLASS 5: Active, Full-time Teacher, except a Teacher in any other Class

CLASS 6: Retired Administrator

CLASS 7: Active, Full-time District Office Employee

CLASS 8: Active, Part-time Teacher

INDIVIDUAL REINSTATEMENT: 6 months

MINIMUM PARTICIPATION REQUIREMENTS: Percentage: 100% Number of Insureds: 10

AMOUNT OF INSURANCE:

Basic Life:

CLASS 1: $200,000, not to exceed five (5) times Earnings.

CLASS 2, 6 & 7: $150,000.

CLASS 3 & 8: $50,000.

CLASS 4 & 5: $100,000.

CLASS 1, 2, 3 & 4: For Insureds age 65 and over, the Amount of Basic Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 64
65-69	65%
70-74	50%
75+	30%

CLASS 5, 7 & 8: For Insureds age 70 and over, the Amount of Basic Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 70 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 69
70-74	50%
75+	30%

CLASS 6: For Insureds age 65 and over, the Amount of Basic Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

Age	**Percentage of available or in force amount at age 64**
65+	65%

Coverage terminates when the Insured attains age 67.

The Life amount will be reduced by any benefit paid under the Accelerated Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the Policy Anniversary Date coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, the Insured must be Actively At Work on the date of the change. If an Insured is not Actively At Work when the change should take effect, the change will take effect on the day after the Insured has been Actively At Work in an Eligible Class for one full day.

CONTRIBUTIONS: Persons: Basic Insurance: 0%

DEFINITIONS

"We," "us" and "our" means Reliance Standard Life Insurance Company.

"You," "your" and "yours" means the employer, union or other entity to which the Policy is issued and which is deemed the Policyholder.

"Eligible Person" means a person who meets the eligibility requirements of the Policy.

"Insured" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at work" and "active work" means the person actually performing on a Full-time or Part-time basis each and every duty pertaining to his/her job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

CLASS 1, 2, 3, 4, 5 & 7: "Full-time" means working for you for a minimum of 20 hours during a person's regularly scheduled work week.

CLASS 8: "Part-time" means working for you for a minimum of 15 hours per week and 150 days per year.

"The date he/she retires" or "retirement" means the effective date of an Insured's:

(1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with you;
(2) retirement pension benefits under any plan which you sponsor, or make or have made contributions; or
(3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

CLASS 1: "Earnings", as used in the SCHEDULE OF BENEFITS section, means the Insured’s annual salary received from you on the Policy Anniversary Date just before the date of loss, prior to any deductions to a 401(k) and Section 125 plan. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed 40 hours per week, times 52 weeks, will be used to determine annual earnings.

If the Insured was not employed by you on the Policy Anniversary Date just before the date of loss, Earnings, as defined above, will be as received from you on the Insured's Individual Effective Date just before the date of loss.

CLASS 1, 2, 3, 4, 5, 7 & 8: "Total Disability", as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means an Insured's complete inability to engage in any type of work for wage or profit for which he/she is suited by education, training or experience.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract between you and us is this Policy, your application (a copy of which is attached at issue), and any endorsements and amendments.

CHANGES

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing. It must also be signed by one of our executive officers and attached to this Policy.

INCONTESTABILITY

Any statement made in your application will be deemed a representation, not a warranty. We cannot contest the validity of this Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium. All other Policy terms will remain applicable.

Any statements made by you, any Insured, or on behalf of any Insured to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

   (a) it is in a written form signed by the Insured, or on behalf of the Insured; and

   (b) a copy of such written instrument is or has been furnished to the Insured, the Insured's beneficiary or legal representative.

(2) If the statement relates to an Insured's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during the lifetime of the Insured.

RECORDS MAINTAINED

You must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR

Clerical errors in connection with this Policy or delays in keeping records for this Policy, whether by you, us, or the Plan Administrator:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

Clerical errors include (but are not limited to) the payment of premium for coverage not provided by this Policy. If appropriate, a fair adjustment of premium will be made to correct a clerical error. Such adjustments will be limited to the twelve (12) month period preceding the date we receive proof from you that an adjustment due to overpayment of premium should be made or the date we discover that premium has been underpaid.

MISSTATEMENT OF FACTS

If relevant facts about any person were misstated:

(1) an adjustment of the premium will be made; and
(2) the true facts will decide what amount of insurance is valid under this Policy.

If any misstated fact impacts the amount of premium that should have been paid, any benefit payable shall be in the amount the paid premium would have purchased based on the correct fact(s).

ASSIGNMENT

Ownership of any benefit provided under this Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

CONFORMITY WITH STATE LAWS

Any section of this Policy, which on its effective date, conflicts with the laws of the state in which this Policy is issued, that is not otherwise pre-empted, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE

We will send to you a certificate for distribution to each Insured and you agree to distribute a certificate to each Insured. The certificate will outline the insurance coverage and to whom benefits are payable.

POLICY TERMINATION

You may cancel this Policy at any time by providing us with written notice. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy if:

(1) the premium is not paid at the end of the grace period; or

(2) the number of Insureds is less than the Minimum Participation Number on the Schedule of Benefits; or

(3) the percentage of eligible persons insured is less than the Minimum Participation Percentage on the Schedule of Benefits.

If we cancel because of (1) above, the Policy will be cancelled at the end of the grace period. If we cancel because of (2) or (3) above, we will give you thirty-one (31) days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date the Policy is cancelled. We will return, pro-rata, any part of the premium paid beyond the date the Policy is cancelled.

Termination of this Policy will not affect any claim which began prior to termination.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she is a member of an Eligible Class, as shown on the Schedule of Benefits page.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

If an Eligible Person pays a part of the premium, he/she must apply in writing for the insurance to go into effect. He/she will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if he/she applies on or before that date; or

(2) the first of the month coinciding with or next following the date he/she applies, if he/she applies within thirty-one (31) days from the date he/she first met the eligibility requirements; or

(3) the first of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if a person applies:

   (a) after thirty-one (31) days from the date he/she first becomes eligible; or
   (b) after he/she terminated this insurance but he/she remained in a class eligible for this insurance; or
   (c) for an Amount of Insurance greater than the guaranteed issue Amount of Insurance shown on the Schedule of Benefits, if applicable; or
   (d) for an Amount of Insurance greater than he/she was insured for under the prior group life insurance plan carrier, if applicable; or
   (e) after being eligible for coverage under a prior group life insurance plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or

(4) the date premium is remitted.

Proof of good health forms are available from us upon request. It is your responsibility to provide proof of good health forms to your employees when required.

Changes in an Insured's Amount of Insurance are effective as shown on the Schedule of Benefits.

If the Eligible Person is not Actively at Work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to Active Work in an Eligible Class for one full day.*

TERMINATION OF INDIVIDUAL INSURANCE:

CLASS 1, 2, 3, 4, 5, 7 & 8: The insurance of an Insured will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the end of the month the Insured ceases to be in a class eligible for this insurance; however, for Employees that completed the school year and satisfied their contract, coverage will terminate on August 31st; or

(3) the end of the period for which premium has been paid for the Insured; or

(4) the date the Insured enters military service on active duty (not including Reserve or National Guard).

The insurance of an Insured may be continued, by payment of premium, beyond the date the Insured ceases to be eligible for this insurance, but not longer than: (1) twelve (12) months, if due to illness or injury; or (2) twelve (12) weeks, if due to an approved leave of absence or lay-off. Insurance may also be continued due to termination of employment as set forth under the CONTINUATION OF INSURANCE provision.

CLASS 6: The insurance of an Insured will terminate on the first of the following to occur:

(1) the date this Policy terminates; or

(2) the date the Insured ceases to be in a class eligible for this insurance; or**

(3) the end of the period for which premium has been paid for the Insured; or

(4) the date the Insured enters military service on active duty (not including Reserve or National Guard).

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if he/she is on an approved leave of absence.

The former Insured must return to Active Work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

The insurance will go into effect on the day he/she returns to Active Work for one full day. If a former Insured returns after having resigned or having been discharged, he/she will be required to fulfill the Eligibility Requirements of this Policy again.

If an Eligible Person requests insurance after previously terminating insurance at his/her request or for failure to pay premium when due, proof of good health must be approved by us before his/her insurance coverage may be reinstated.

* Not Applicable to retirees.
** Insurance will not terminate at retirement, the amount of insurance will be as shown on the Schedule of Benefits.

CONTINUATION OF INSURANCE

Continuation of Coverage

An Insured may elect to continue insurance for himself/herself if: (a) such Insured is voluntarily or involuntarily terminated or laid off from his/her employment; and (b) the Policy remains in force for any active employee of the Policyholder.

An Insured is considered laid off from employment if his/her hours are reduced to the point where he/she is no longer eligible for coverage under the Policy. Termination does not include discharge for gross misconduct.

Responsibility of Employee

If the Insured elects to continue coverage for himself/herself, he/she must pay the cost of continued coverage to the Policyholder on a monthly basis. The amount of premium charged cannot exceed 102 percent of the cost of the plan for such period of coverage for other similarly situated employees with respect to whom neither termination or layoff has occurred, without respect to whether such cost is paid by the Policyholder or employee.

An Insured is eligible to continue insurance for himself/herself until the earliest of: (a) the date he/she obtains coverage under another group policy; or (b) eighteen (18) months after the termination or layoff from employment.

Notice of Options

Within 14 days after termination or layoff, the Policyholder must send a notice of continuation to the Insured by first class certified mail informing him/her of the following: (a) the right to continue insurance; (b) the amount the Insured must pay monthly to the Policyholder to retain the insurance; (c) the manner in which and the office of the Policyholder to which the payment to the Policyholder must be made; and (d) the time by which the payments to the Policyholder must be made to retain coverage.

The Insured has sixty (60) days within which to elect continued insurance for himself/herself. The sixty (60) day period will begin on the later of: (a) the date insurance would otherwise terminate; or (b) the date the Insured receives notice of the right to continue insurance.

If the Insured dies during the sixty (60) day election period and before the Insured makes an election to continue or reject continuation, such Insured will be considered to have elected continuation of coverage. The Insured's previously selected beneficiary would then be entitled to a death benefit equal to the amount of insurance that could have been continued less any unpaid premium on such amount as of the date of death.

Responsibility of Policyholder and Us

If the Policyholder fails to notify the Insured of the options set forth above or if after timely receipt of the monthly payment from the Insured, the Policyholder fails to make the payment to us, with the result that the Insured’s coverage is terminated, the Policyholder is still liable for his/her coverage to the same extent as we would be if the coverage were still in effect.

Conversion

After the Insured’s coverage terminates under the Continuation provision, such Insured may obtain, at his/her expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance providing the same or substantially similar benefits. A policy providing reduced benefits at a reduced premium rate may be accepted by the Insured in lieu of the coverage otherwise required by this provision.

CONVERSION PRIVILEGE

An Insured can use this privilege when his/her insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of this Policy's classes or due to the termination or amendment of this Policy, an individual Life Insurance Policy may be issued. The Insured is entitled to a policy without disability or supplemental benefits. A written application for the policy must be made by the Insured within thirty-one (31) days after he/she terminates. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

   (1) The policy will, at the option of the Insured, be on any one of our forms, except term life insurance. It will be the standard type issued by us for the age and amount applied for;

   (2) The policy issued will be for an amount not over what the Insured had before he/she terminated;

   (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and the Insured's age at date of policy issue; and

   (4) Proof of good health is not required.

B. If the insurance reduces, as may be provided in this Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.

C. If an Insured dies during the time provided in A above in which he/she is entitled to apply for an individual policy, we will pay the benefit under this Policy that he/she was entitled to convert. This will be done whether or not the Insured applied for the individual policy.

D. Any policy issued with respect to A or B above will be put in force at the end of the thirty-one (31) day period in which application must be made.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the Policy face page.

PREMIUM RATE: The premium due will be the rate per $1,000 of benefit multiplied by the entire amount of benefit volume then in force. We will furnish to you the premium rate on the Policy effective date and when it is changed. We have the right to change the premium rate:

(1) on any premium due date after the Policy is in force for 36 months;

(2) when the extent of coverage is changed by amendment; or

(3) on any premium due date on or after the Policy is in force for 12 months if the entire amount of the benefit volume changes by 15% or more from the entire amount of benefit volume on the Policy effective date.

We will not change the premium rate due to (1) or (3) above more than once in any twelve (12) month period. We will tell you in writing at least thirty-one (31) days before the date of a change due to (1) or (3) above.

GRACE PERIOD: You may pay the premium up to 31 days after the date it is due. The Policy stays in force during this time. If the premium is not paid during the grace period, the Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date the Policy is cancelled.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by the Insured to receive benefits at the Insured's death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date the Insured signs it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If the Insured names more than one beneficiary to share the benefit, he/she must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if the Insured wishes to change the designation. His/her consent is also not needed to make any changes in this Policy.

If the beneficiary dies at the same time as the Insured, or within fifteen (15) days after his/her death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise.

If the Insured has not named a beneficiary, or the named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

(1) the Insured's legal spouse;
(2) the Insured's surviving child(ren) (including legally adopted child(ren)), in equal shares;
(3) the Insured's surviving parents, in equal shares;
(4) the Insured's surviving siblings, in equal shares; or, if none of the above,
(5) the Insured's estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If the Insured has not named a beneficiary, or the named beneficiary is not surviving at the Insured's death, we may pay up to $2,500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with the Insured's last illness, death or burial.

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or

(2) is appointed to receive the proceeds; and

(3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

SETTLEMENT OPTIONS

The Insured may elect a lump sum payment or a different way in which payment of the Amount of Insurance can be made. He/she must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under $2,000 or option payments of less than $20.00 each are not eligible.

If no instructions for a settlement option are in effect at the death of the Insured, the beneficiary may make the election, with our consent.

OPTION A – FIXED TIME PAYMENT OPTION

Equal monthly payments will be made for any period chosen, up to thirty (30) years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change it. This change will apply only to requests for settlement elected after this change.

Option A Table
Minimum Monthly Payment Rates for each $1,000 Applied

Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment
1	$83.71	7	$12.32	13	$6.83	19	$4.81	25	$3.76
2	42.07	8	10.83	14	6.37	20	4.59	26	3.64
3	28.18	9	9.68	15	5.98	21	4.40	27	3.52
4	21.24	10	8.75	16	5.63	22	4.22	28	3.41
5	17.08	11	7.99	17	5.33	23	4.05	29	3.31
6	14.30	12	7.36	18	5.05	24	3.90	30	3.21

OPTION B – FIXED AMOUNT PAYMENT OPTION

Each payment will be for an agreed fixed amount. The amount of each payment may not be less than $10.00 for each $1,000 applied. Interest will be credited each month on the unpaid balance and added to it. This interest will be at a rate set by us, but not less than the equivalent of 1% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

OPTION C – INTEREST PAYMENT OPTION

We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 1% per year.

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the proper representative of the beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

OPTION D – LIFE ANNUITY OPTION

An annuity will be payable during the lifetime of the beneficiary, ceasing with the last payment due prior to the death of the beneficiary.

Requests for settlement options other than the four (4) set out above may be made. A mutual agreement must be reached between the individual entitled to elect and us.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

Applicable to Class 1, 2, 3, 4, 5, 7 & 8:

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

(1) the Insured becomes totally disabled prior to age 60;
(2) the Total Disability begins while he/she is insured;
(3) the Total Disability begins while this Policy is in force;
(4) the Total Disability lasts for at least 2 months;
(5) the premium continues to be paid; and
(6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Insured is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask the Insured to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. The Insured may be required to be examined by a Physician approved by us as part of the proof. We will not require the Insured to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage on the life of the Insured that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if the Insured had not been totally disabled. If the Insured dies, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for an Insured will cease on the earliest of:

(1) the date he/she no longer meets the definition of Total Disability; or
(2) the date he/she refuses to be examined; or
(3) the date he/she fails to furnish the required proof of Total Disability; or
(4) the date he/she becomes age 65; or
(5) the date he/she retires.

The Insured may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. An Insured is not entitled to conversion if he/she returns to work and is again eligible for the insurance under this Policy. If the Insured uses the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

If the Insured qualifies for benefits in accordance with the Waiver of Premium in Event of Total Disability provision because he/she has been diagnosed by a Physician as totally disabled due to the following Condition(s) or Procedure(s), as later defined;

(1) Life Threatening Cancer; or
(2) Heart Attack (Myocardial Infarction); or
(3) Kidney (Renal) Failure; or
(4) Receipt of Major Organ Transplant; or
(5) Stroke,

we will pay to the Insured an additional, one time, lump sum benefit in an amount equal to 10% of the death benefit under the basic life portion of this Policy up to a maximum of $100,000.

This lump sum benefit applies only to the first Condition or Procedure to occur among those hereinafter defined which qualifies the Insured for waiver of premium benefits. No further lump sum benefits will be payable under this provision during the same or any subsequent periods of Total Disability, or as a result of the occurrence of any other Condition or Procedure.

Definition(s):

"Condition(s) or Procedure(s)" mean only the following:

"Life Threatening Cancer" means a malignant neoplasm (including hematologic malignancy), as diagnosed by a Physician who is a board certified oncologist, and which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded. The following types of cancer are not considered a Life Threatening Cancer: (1) early prostate cancer diagnosed as T2c or less according to the TNM scale; (2) colorectal cancer diagnosed as T2, N1, M0 or less according to the TNM scale; (3) breast cancer diagnosed as T3, N2, M0 or less according to the TNM scale; (4) First Carcinoma in Situ; (5) pre-malignant lesions (such as intraepithelial neoplasia); (6) brain glioma; (7) benign tumors or polyps; (8) tumors in the presence of the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS); or (9) any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life Threatening Cancers.

"First Carcinoma in Situ" means the first diagnosis of cancer in which the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. First Carcinoma in Situ must be diagnosed pursuant to a pathological diagnosis or clinical diagnosis.

"Heart Attack (Myocardial Infarction)" means the death of a segment of the heart muscle as a result of a blockage of one or more coronary arteries. In order to be covered under this provision, the diagnosis by a Physician of Heart Attack (Myocardial Infarction) must be based on:

(1) new electrocardiographic changes consistent with and supporting a diagnosis of Heart Attack (Myocardial Infarction); and
(2) a concurrent diagnostic elevation of cardiac enzymes; and
(3) therapeutic and functional classifications, 3 or above and C or above respectively, according to the New York Heart Association.

"Kidney (Renal) Failure" means the chronic irreversible failure of both of the kidneys (end stage renal disease), which requires treatment with dialysis on a regular basis. Kidney Failure is covered under this provision only if the diagnosis has been made by a Physician who is a board certified nephrologist.

"Physician" means a duly licensed practitioner who is recognized by the law of the jurisdiction in which treatment is received as qualified to treat the type of condition for which claim is made. The Physician may not be the Insured or a member of his/her immediate family and must be approved by us.

"Receipt of Major Organ Transplant" means that the Insured has been the recipient of a major organ transplant and that there is clinical evidence of an Insured's major organ(s) failure which, according to the diagnosis of a Physician, required the failing organ(s) or tissue of the Insured to be replaced with organ(s) or tissue from a suitable donor under generally accepted medical procedures. Organs or tissues covered by this definition are limited to liver, kidney, lung, entire heart, pancreas, or pancreas-kidney.

"Stroke" means a cerebrovascular accident or infarction (death) of brain tissue, as diagnosed by a Physician, which is caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least one hundred eighty (180) days following the occurrence of the Stroke. Stroke does not include Transient Ischemic Attack (TIA) or other cerebral vascular events.

Receipt of this additional lump sum payment may be taxable. The Insured should seek assistance from his/her own personal tax advisor.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name, the Policy Number and your name.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within fifteen (15) days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within ninety (90) days. If it is not reasonably possible to give proof within ninety (90) days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to the Insured if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have an Insured examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina and Michigan, six (6) years) from the time written proof of loss is required to be submitted.

EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependent, if applicable, in accordance with your policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for such Insured and his/her Insured Dependents, if applicable, continues to be paid during the leave; and
(2) you have approved the Insured's leave in writing and provide a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependents, if applicable, in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured and his or her Insured Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

This Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While the Insured is on a Family and Medical Leave of Absence for any reason other than his or her own illness, injury or disability or Military Services Leave of Absence he or she will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective for an Insured who is not considered Actively at Work until the Insured has returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in this Policy.

The Insured's coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

(1) the date this Policy terminates; or
(2) the end of the period for which premium has been paid for the Insured; or
(3) the date such leave should end in accordance with your policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should you choose not to continue the Insured's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured's coverage as well as any dependent coverage, if applicable, will be reinstated.

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION TO THE GROUP TERM LIFE PLAN. THE INSURED MAY ELECT TO TAKE THIS ACCELERATION UNDER THE CONDITIONS DESCRIBED IN THIS RIDER.

THIS RIDER DOES NOT PROVIDE LONG-TERM CARE COVERAGE MEETING THE REQUIREMENTS OF SECTION 62A.46 TO 62A.56.

RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT.

Attached to Group Policy Number: GL 682975
Issued to Group Policyholder: Annandale Public School ISD 0876

This Rider is attached to and made a part of the Policy indicated above. The Policy is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as “we", “us", “our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured’s Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Policy at the death of the Insured, subject to all Policy provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Accelerated Benefit Rider.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured’s illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 12 months.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

(1) the Insured must be Certified as Terminally Ill prior to age 65; and

(2) the Insured must make a Written Request; and

(3) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

(1) The Death Benefit payable for such Insured will be reduced by the amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.

(2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

MISSTATEMENT OF AGE OR SEX: The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

TERMINATION OF AN INDIVIDUAL'S COVERAGE UNDER THIS RIDER: The coverage of any Insured under this Rider will terminate on the first of the following:

(1) the date his coverage under the Policy terminates;

(2) the date of payment of the Accelerated Benefit for his Terminal Illness; or

(3) the date he attains age 75.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herein.

In witness whereof, we have caused this Rider to be signed by our Secretary.

Secretary

RELIANCE STANDARD LIFE INSURANCE COMPANY
2001 Market Street, Suite 1500
Philadelphia, PA 19103-7090
(267) 256-3500
Toll-free telephone number: 1-800-644-1103

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

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

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

Minnesota Life & Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear lake, MN 55110
(651) 407-3149

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

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

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