NORTH DAKOTA

CERTIFICATES OF INSURANCE

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CERTIFICATES OF INSURANCE
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	PAGE #S	GROUP CERTIFICATES OF INSURANCE
	02-19	Group Accident Only Insurance Certificates of Insurance (Family 703) underwritten by: Guarantee Trust Life Insurance Company

ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS.
CALL **866-438-4274** WITH ANY QUESTIONS.

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

CERTIFICATE OF INSURANCE

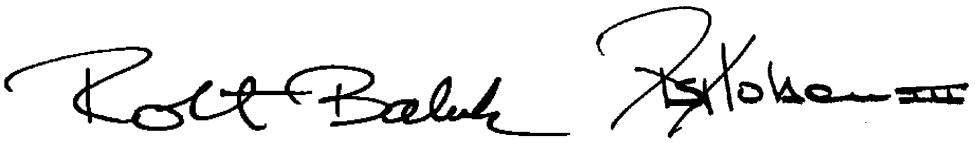
This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY



Secretary President

GROUP ACCIDENT ONLY COVERAGE

NON-PARTICIPATING

YOU MAY RETURN THIS CERTIFICATE WITHIN 10 DAYS OF ITS DELIVERY AND HAVE THE PREMIUM REFUNDED, IF AFTER EXAMINATION OF THIS CERTIFICATE, YOU ARE NOT SATISFIED FOR ANY REASON

GACNDCV100

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DEFINITIONS

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

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means. Air ambulance charges are only eligible for transportation from the site of an Emergency to the nearest appropriate facility.

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

Company: Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

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

Covered Person: A person:
- Who is eligible for coverage as the Insured or as a Dependent;
- Who has been accepted for coverage or has been automatically added;
- Who has paid the required premium; and
- Whose coverage has become effective and has not terminated.

Deductible: A dollar amount of Covered Charges a Covered Person must pay before We pay any benefits under the Policy. The Deductible is shown on the Schedule of Benefits.

Dependent: A person who is:
- Your legally married spouse, residing with You;
- Your child who is dependent upon You for support and maintenance and is under the age of 26;
- Your child who is dependent upon You for support and maintenance, and is incapable of self-sustaining employment by reason of mental or physical handicap provided proof of incapacity is provided to Us within 31 days of the child's attainment of the limiting age and subsequently as required by Us but not more frequently than once every 2 years thereafter; or
- A Dependent of a Dependent.

The term child refers to Your unmarried:
- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date You married the child's parent.
- Adopted child, including a child placed with You for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

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

Durable Medical Equipment: A device which:
- is primarily and customarily used for medical purposes and is specially equipped with features and functions that are generally not required in the absence of Injury;
- is used exclusively by a Covered Person;
- is routinely used in a Hospital but can be used effectively in a non-medical facility;
- can be expected to make a meaningful contribution to a Covered Person's Injury; and
- Is prescribed by a Doctor and the device is Medically Necessary for a Covered Person's rehabilitation.

Durable Medical Equipment does not include:
- comfort and convenience items;
- equipment that can be used by Family Members other than a Covered Person;
- health exercise equipment; and
- equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to a Covered Person's Residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a Covered Person could reasonably expect that: (1) his life or health would be in serious jeopardy; (2) his bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

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

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

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered Charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Family Member: A person who is related to a Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child).

Home Health Agency: An agency which is licensed as a Home Health Agency by state or local government. It may offer the following services:

- part-time or periodic skilled nursing services by a registered nurse or licensed vocational nurse;
- part-time or periodic home health aide services which offer supportive services in the home under the supervision of a Registered Nurse or a physical, speech or occupational therapist;
- physical, occupational or speech therapy; and
- medical supplies, drugs and medicines prescribed by a Doctor and related pharmaceutical services, and laboratory services to the limit these charges or costs would be covered under the Policy if the Covered Person was Hospital Confined.

Home Health Care: Services by a Home Health Agency for the care and treatment of a Covered Person who is under the direct care and supervision of a Doctor but only if:

- services would have been covered in a medical facility if Home Health Care were not given; and
- a Home Health Care treatment plan is set up, in writing and approved by a Doctor.

Hospice Care: Services provided by a public agency or private organization or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual

for whom a certified medical prognosis has been made indicating a life expectancy of 6 months of less and who has elected to receive such care in lieu of other medical benefits available under the Policy.

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

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

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

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse.

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

Injury: Bodily injury due to an Accident which:

- results directly and independently of disease, bodily infirmity or any other causes;
- solely, directly and independently of all other causes results in medical expense;
- occurs after the effective date of the a Covered Person's coverage under the Policy; and
- occurs while the Policy is in force.

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

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

- he or she is eligible for coverage under the Policy;
- he or she has been accepted for coverage under the Policy or has been automatically added;
- premium has been paid for him or her; and
- his or her coverage has become effective and has not terminated.

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

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

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

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

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

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

Orthopedic Appliances: Any supportive device or appliance used in treating a Covered Person's Injury.

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

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

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

Policyholder: The entity to which the Policy is issued.

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

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

- the actual amount charged by the provider;
- the negotiated rate; or

- the charge which would have been made by the provider (Doctor, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

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

Rehabilitation Facility: An institution, or part of an institution, licensed, accredited or certified by the State which:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities;
- is primarily engaged in providing comprehensive multi-disciplinary physical services or rehabilitation inpatient care; and
- has a transfer agreement with one or more Hospitals.

Rehabilitation Facility does not include an institution which provides only minimal care, custodial care, care for the terminally ill, or part-time care services. It also does not include an institution which primarily provides treatment for mental disorders; chemical dependency or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medial conditions; drug addiction or alcoholism.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

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

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

You, Your and Yours: The person to whom this certificate is issued and whose insurance is in force under the terms of the Policy.

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CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the first of the month that falls or next follows the later of:

- the Policy Effective Date; or
- the date the person is eligible;
- the date of enrollment.

Dependents Acquired After Effective Date:

Newborn Child: An Insured's newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for an Injury. However, the Insured must

notify Us in writing within 31 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 31 day period.

Adopted Child: Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption or the date of entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage for such child will be for Injury. However, the Insured must notify Us in writing within 31 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 31 day period.

Other Than Newborn or Adopted Child: A person who qualifies as a Dependent after the Effective Date of coverage may be insured under the Policy. Enrollment and premium must be received by Us within 31 days after the date the person first qualifies as a Dependent, and the required premium must be paid. Coverage is effective upon receipt of enrollment and premium by Us or Our authorized representative.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:
- the date the Policy terminates;
- the date the Covered Person ceases to be an Eligible Person;
- the end of the period for which any applicable premium has been paid;
- the date of fraud or misrepresentation of a material fact by a Covered Person;

Termination of coverage is subject to the Extension of Benefits provision.
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CONTINUATION OF COVERAGE

In The Event of Dissolution of Marriage

If Your marriage is dissolved by a valid decree of dissolution and if Your spouse is a Covered Person on the date of the decree of dissolution, then the Dependent spouse's coverage will continue in force under the policy, subject to its provisions, if the Dependent spouse pays the first premium required for the continued coverage within 31 days after the entry of the decree of dissolution.

If the Dependent spouse continues coverage pursuant to this provision, We will issue him or her a new Certificate as evidence of coverage under the Policy.

For a Dependent Child Reaching the Limiting Age

If a Dependent child no longer qualifies as a Dependent, then the Dependent child's coverage will continue in force under the Policy, subject to its provisions, if the Dependent child pays the first premium required for the continued coverage within 31 days after the date he or she no longer qualifies as a Dependent child.

If the Dependent child continues coverage pursuant to this provision, We will issue him or her a new Certificate as evidence of coverage under the Policy.
GACXXCC100

EXTENSION OF BENEFITS

In the event of Total Disability

If a Covered Person is Totally Disabled due to an Injury on the date the Policy terminates, We will extend that Covered Person's benefits for the Injury which caused the Total Disability. Benefits will be paid as if coverage had remained in effect.

Total Disability/Totally Disabled for the purpose of Extension of Benefits means, with respect to You, the complete inability to perform all of the substantial and material duties of Your occupation and any other gainful occupation in which You earn substantially the same compensation earned prior to disability. With respect to a covered Dependent, Hospital Confinement.

Extension of benefits will end at the earlier of:

- the end of Total Disability;
- the end of a 12 month period following the date the Policy terminates; or
- the date the Maximum Benefit Amount, per Injury is reached.

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SCOPE OF ACCIDENT COVERAGE

24-Hour-A-Day Accident Coverage: A Covered Person is covered for Injury which is incurred on a 24-hour per day basis.
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ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

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

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means. Severance means the complete separation and dismemberment of the part from the body.

Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.
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ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by an Accident.

Covered Charges are payable only for an Injury:

- for which the first treatment or service is incurred within the Initial Treatment Period; and
- for which expense for all treatment or service is incurred within the Benefit Period.

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the Insured Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the definitions, limitations, exclusions and other provisions of the Policy.

Other Valid and Collectible Insurance or Plan

After the Deductible has been satisfied, We will pay the Insured Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Injury. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of this Certificate.

You must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, You fail to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had You filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.
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EXCLUSIONS

The Policy does not provide benefits for:

- Treatment, services or supplies which:
  - Are not Medically Necessary;
  - Are not prescribed by a Doctor as necessary to treat an Injury;
  - Are determined to be Experimental/Investigational in nature;
  - Are received without charge or legal obligation to pay;
  - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
  - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not.
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker's Compensation, Employer Liability law or Occupational Disease Act or Law.
- Dental treatment, except as specifically stated.
- Injury sustained while committing or attempting to commit a felony.
- Prescription Drugs except as specifically stated.
- Suicide or attempted suicide while sane or insane.
- Intentionally self-inflicted Injury.
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs.
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.
- Injury sustained while participating in or practicing for any professional or intercollegiate sports activity, except as specifically provided.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.
- Injury sustained flying in an ultra light, hang gliding, parachuting or bungee-cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere**.**
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's).
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program.
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
- Covered Charges incurred outside of the United States or its possessions, unless such Covered Charges are incurred while a Covered Person is on a trip of not more than 60 days.
- Competing in motor sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;

- Spelunking (exploring caves);
- Handling or working with dangerous animals.
- Injury sustained while participating in a rodeo.
- Reinjury or complications of an Injury caused or contributed to by a Pre-existing Condition.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.

PREMIUM

Payment of Premium/Due Date: All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our Home Office by the premium due date. Coverage will not become effective until the required premium is received at Our Home Office or by Our authorized representative.

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

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

Coverage terminates on the last day for which premium has been paid.

Reinstatement: If coverage terminates due to non-payment of premium, then a subsequent acceptance of premium by Us or by an agent, without requiring an application for reinstatement, will reinstate the insurance.

The reinstated Certificate will cover only losses that begin after the date of reinstatement. In all other respects, Your rights and Ours will be the same as before insurance terminated, unless there are new provisions added due to reinstatement. The premium We accept for reinstatement may be used for the period for which premiums had not been paid. We can apply the premium for as many as 60 days before the date of reinstatement.
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CLAIM PROVISIONS

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

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

Proof of Loss: Written proof of loss for Hospital confinement must be given to the Company or its authorized representative within 60 days after release from the Hospital. Proof of any other covered loss must be given to the Company or its authorized representative not later than 90 days after the covered loss. If proof of loss is not given within the time specified, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

Payment of Claims: Benefits payable under the Policy for Your loss of life will be paid to Your beneficiary on record with the Company. Benefits payable for losses sustained by Your Dependents are payable to You. Any other payable benefits remaining unpaid at the time of a Covered Person's death may, at Our option, be paid to a Covered Person's next of kin or to a Covered Person's estate. All other benefits will be payable to a Covered Person or the medical services provider if We have received a valid assignment by the Covered Person.

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

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

Change of Beneficiary: You have the right to change the beneficiary and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

Physical Examination and Autopsy: The Company, at its own expense, shall have the right and opportunity to examine a Covered Person as it may reasonably require while a claim is pending. The Company, at its own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to a Covered Person's rights of recovery against any person who might be acknowledged liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery.
GACXXCP100

GENERAL PROVISIONS

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

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

Incontestability: After 2 years from the Covered Person's Effective Date of coverage, no statements, except fraudulent misstatements, made by [the Covered Person in the application for such coverage shall be used to void the Covered Person's coverage or to deny a claim for loss incurred or disability commencing after the expiration of such 2 year period

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

Workers' Compensation: This Certificate is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

Conformity With State Statutes: If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.
GACXXGP100

SCHEDULE OF BENEFITS

Policyholder:	United Business Association (UBA)
Eligible Persons:	All members of United Business Association and their Dependent Spouse and Children
Scope of Coverage:	24-Hour Accident

GAXXSOB100

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

The Principal Sum	$ 1,000.00
Loss of Life	$ 1,000.00
Loss of Both Hands	$ 1,000.00
Loss of Both Feet	$ 1,000.00
Loss of the Entire Sight of Both Eyes	$ 1,000.00
Loss of One Hand and One Foot	$ 1,000.00
Loss of Speech and Hearing	$ 1,000.00
Loss of One Hand or One Foot and Entire Sight of One Eye	$ 1,000.00
Loss of One Hand or One Foot	$ 500.00
Loss of Entire Sight of One Eye	$ 500.00
Loss of Speech or Hearing	$ 500.00
Loss of Hearing One Ear	$ 250.00

GAXXADDSOB202

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Benefit Amount Per Injury	$ 10,000.00
Deductible Per Injury	$ 100.00
Insured Percent (except as specifically stated in Covered Charges)	100%
Initial Treatment Period	12 weeks
Benefit Period	52 weeks

GAXXAMESOB101

SCHEDULE OF BENEFITS (Continued)

COVERED CHARGES	**Maximum Amount**
Hospital room and board, and general nursing care, up to the semi-private room rate.	Up to Policy Limits
Hospital miscellaneous expense during Hospital Confinement or for outpatient surgery under general anesthetic, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies	Up to Policy Limits
Doctor's fees for surgery.	$1000
Anesthesia services.	$250
Doctor's visits, inpatient and outpatient, per visit	$75
Hospital Emergency care.	$500
X-ray and laboratory services.	$250
Ambulance expense.	$250
Prescription Drug expense.	Up to Policy Limits
Dental treatment for Injury to Sound Natural Teeth per visit	$250
Registered nurse expense.	Up to Policy Limits
Chiropractic per visit	$20
Physical therapy per visit	$25
Durable Medical Equipment	$50

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

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

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

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

1. Life Insurance

   a. $300,000 in death benefits

   b. $100,000 in cash surrender or withdrawal values

2. Health Insurance

   a. $500,000 for health benefit plans (see definition below)

   b. $300,000 in disability income insurance benefits

   c. $300,000 in long-term care insurance benefits

   d. $100,000 in other types of health insurance benefits

3. Annuities

   a. $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

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

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

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

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

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

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

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

GUARANTEE TRUST LIFE INSURANCE COMPANY
PRIVACY NOTICE

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

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

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

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

INFORMATION WE COLLECT AND SOURCES OF INFORMATION

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

- Information we receive on the application for insurance or other forms *(such as name, address, telephone number, age, social security number, and beneficiary designation.)*
- Information about our customer's transactions with us and our affiliates *(such as the type of insurance product purchased, the premium paid, the method of purchase, and payment history.)*
- Information we receive from third party reports, *(such as consumer-reporting/credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.)*

INFORMATION WE DISCLOSE

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

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

- Affiliates – We may share information with our affiliates. Our affiliates offer products and services that may complement insurance purchases and we believe may be of interest to our customers.
- Service Providers **–** We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction a customer requests or authorizes; to develop or maintain computer software; or to perform market research.
- Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY

All medical information is kept confidential. We will not use or share, internally or with third-parties, our customer's medical information except for the purposes of:

- Underwriting;
- Administering the policy or claim;
- As permitted or required by law; or
- As authorized by the customer.

SECURITY AND CONFIDENTIALITY OF CUSTOMER INFORMATION

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

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