Term Life and AD&D Insurance

Employee Benefit Booklet

FORT DEARBORN LIFE INSURANCE COMPANY
Downers Grove, Illinois

COUNTY OF MARTIN

Group Number: F008893-0001

Class 1-01

08/08/2006

FORT DEARBORN LIFE INSURANCE COMPANY

(A stock life insurance company herein called "We", "Us", "Our")

Administrative Office:

1020 31st Street ● Downers Grove, Illinois 60515-5591

CERTIFICATE (NC)

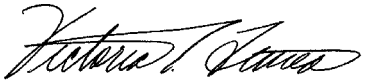
Important Cancellation Information: Your coverage may be canceled by the Company. Please read the section called "Termination of Employee Coverage." PLEASE READ CAREFULLY.

We agree to pay benefits subject to the provisions, definitions, limitations, and conditions of the master policy. The master policy (herein called the Policy) is a contract issued by Fort Dearborn Life Insurance Company to your Employer (herein called the Policyholder). Coverage under the Policy is available to Employees of North Carolina Employers only. The Policy may be changed at any time by a written agreement between Fort Dearborn Life Insurance Company and the Policyholder.

This is your certificate of coverage as long as you are eligible for insurance. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

If you have any questions, please contact the Benefits Administrator at your place of employment or write to us. We will assist you in any way we can to help you understand your benefits.

President



Secretary

Group Insurance Certificate
Non-Participating
Term Life and AD&D Insurance

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SCHEDULE OF BENEFITS

POLICYHOLDER: COUNTY OF MARTIN

POLICY NUMBER: F008893-0001

CLASS OF INSUREDS	**DEFINITION**
1- 01	All active full-time employees.

Basic Life Benefit: $10,000.

Benefit Reduction: Benefit reduces to 65% upon attainment of age 65 and reduces by an additional 15% upon attainment of age 70. (All reductions in benefit will be calculated from the original amount.)

Basic AD&D Benefit: $10,000.

Benefit Reduction: Benefit reduces to 65% upon attainment of age 65 and reduces by an additional 15% upon attainment of age 70. (All reductions in benefit will be calculated from the original amount.)

DEFINITIONS (NC)

This section tells You the meaning of special words and phrases used in this Certificate. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or **Accidental** means a sudden, unexpected event that was not reasonably foreseeable.

Actively at Work or **Active Work** means that you are:

1. performing the normal duties of your occupation; and
2. working the number of hours set forth in the Application.

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the Policyholder applied. The Application is attached to and forms a part of this Policy, and shall include any subsequent amendments to the Application.

Base Annual Salary means the gross annual compensation prior to before-tax payroll deductions, if any, which an Insured earns from his occupation with the Policyholder.

It does not include Salary from overtime, bonuses or any other form of extra pay. However, if an Employee's Salary is based in whole or in part on commissions, Base Annual Salary will include the amount paid in commissions during the preceding twelve-month calendar period. An Employee's deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross annual compensation.

Increases to Base Annual Salary which result in a benefit increase of $50,000 or greater and are above the guarantee issue amount will be subject to evidence of insurability satisfactory to Us before the increased benefit can become effective. Receipt of premium before we have approved any evidence of insurability will not constitute acceptance and does not guarantee issuance of any benefit amount prior to our approval.

Basic Weekly Wage means the gross weekly compensation prior to before-tax payroll deductions, if any, which an Insured earns from his occupation with the Policyholder.

It does not include compensation from overtime, bonuses or any other form of extra pay. However, if your compensation is based in whole or in part on commissions, Basic Weekly Wage will include the weekly average paid in commissions during the preceding twelve-month calendar period. Your deferred contributions to a 401K plan or salary reduction contributions to a cafeteria plan which are maintained by the Policyholder will not be deducted when calculating gross weekly compensation.

Base Annual Salary/Basic Weekly Wage for each Insured who is a partner means the Insured's annual/average weekly compensation from the partnership during the calendar year prior to the date of the Insured's loss, as reported on the partnership federal income tax return as the "net Salary (loss) from self-employment" for that year.

If an Insured was not a partner during the calendar year prior to the date of loss, Base Annual Salary/Basic Weekly Wage means the Insured's annual/average weekly compensation (excluding dividends, capital gains, and return of capital) from the partnership prior to the date of the Insured's loss, determined in accordance with the terms of the applicable partnership agreement. In the event of a disagreement between Us and the claimant, an adjustment will be made, if warranted, after the Insured's subsequent federal income tax return is submitted to Us.

No benefits are payable when any of the above calculations result in an amount less than zero.

Base Annual Salary/Basic Weekly Wage for each Insured who is a sole proprietor or shareholder in a Subchapter S corporation or a member in a limited liability company means the Insured's annual/average weekly net taxable

income (excluding dividends, capital gains, and return of capital) derived from the Policyholder for the calendar year prior to the date of the Insured's loss, as reported on his federal income tax return. The Insured's annual/average weekly net taxable income equals A minus B, where:

A = The Insured's annual/average weekly taxable income derived from the Policyholder for the prior calendar year (excluding dividends, capital gains, and return of capital), as reported on the Insured's federal income tax return; and

B = The Insured's annual/average weekly deductible work expenses attributable to his work for the Policyholder during the prior calendar year, as reported on the Insured's federal income tax return.

If an Insured was not a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company during the calendar year prior to the date of the Insured's loss, Base Annual Salary/Basic Weekly Wage means an Insured's annual/average weekly net taxable income derived from the Policyholder for the period he was a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company prior to the date of the Insured's loss. The Insured's annual/average weekly net taxable income will be based on the taxable income derived from the Policyholder for the period of the Insured's work as a sole proprietor or shareholder in a Subchapter S corporation or a member in a Limited Liability Company for You, taking into account his deductible work expenses attributable to his work for the Policyholder during the same period.

No benefits are payable when any of the above calculations result in an amount less than zero.

Contributory means you pay a portion of the premium for this insurance coverage.

Employee means an Actively at Work full-time employee whose principal employment is with the Employer, at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Injury means bodily injury resulting directly from an Accident and independently of all other causes.

Insured means an Employee covered under the Policy.

Male Pronoun whenever used includes the female.

Noncontributory means the Policyholder pays 100% of the premium for this insurance.

Policy means the contract between the Policyholder and Us including the attached Application, which provides group insurance benefits.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy.

Proof under the Accelerated Death Benefit means evidence satisfactory to Us that you are Terminally Ill. We reserve the right to determine, at our sole discretion, if Proof is acceptable.

Terminally Ill under the Accelerated Death Benefit means you have a life expectancy of 12 months or less, due to a medical condition.

Total Disability or **Totally Disabled** under the Waiver of Premium provision means you are completely unable to engage in any occupation for wage or profit because of Sickness or Injury.

You or **Your** means the Employee to whom this Certificate has been delivered.

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

ELIGIBILITY

All Employees who belong to an eligible class and work the minimum number of hours as set forth in the Application are eligible for group insurance. An Employee must be **Actively at Work** for his insurance coverage to become effective.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Noncontributory Benefits)

If you are Actively at Work, you will become insured for Noncontributory benefits under the Policy on the day following completion of the Employee waiting period, if any, set forth in the Application.

If you waive all or a portion of your Noncontributory coverage and choose to enroll at a later date, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EMPLOYEE EFFECTIVE DATE OF COVERAGE
(Contributory Benefits)

You may apply for Contributory insurance coverage at any time. Your coverage will become effective as follows, provided you are Actively at Work on that date:

1. If you sign the enrollment form on or before the end of the waiting period, if any, as stated in the Application, coverage will become effective on the day following completion of the waiting period.

2. If you sign the enrollment form after the end of the waiting period, but within 31 days after that day, coverage will become effective the date you sign the enrollment form.

3. If you sign the enrollment form following this 31-day period, you are considered a late applicant and must furnish evidence of insurability satisfactory to Us before coverage can become effective. Coverage will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

DEFERRED EFFECTIVE DATE

You must be Actively at Work on the date your initial coverage or any increases in coverage are scheduled to begin. If:

1. you are absent from Active Work on the date such coverage would otherwise become effective; and
2. your absence is caused by an injury, illness or layoff,

the effective date of any initial coverage or increased coverage will be deferred until the first day you return to Active Work. You will be considered Actively at Work if you were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

EFFECTIVE DATE IF WE REQUIRE EVIDENCE OF INSURABILITY

If you are required to submit evidence of insurability satisfactory to Fort Dearborn Life Insurance Company, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide written notice of approval.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF BENEFITS

Any change in the amount of your benefits caused by a change in class, change in salary, age reduction or amendment to the Policy will become effective on the effective date of the change. If the change results in an increase in the amount of insurance, you must be Actively at Work on that date. If you are not Actively at Work, the increase will take effect on the day you are again Actively at Work.

ELIGIBILITY AFTER TERMINATION OF EMPLOYMENT

If your coverage ends due to termination of employment you must meet all the requirements of a new Employee if you are rehired at a later date.

GROUP TERM LIFE INSURANCE BENEFIT

BENEFIT

We will pay your beneficiary the amount of life insurance in force as of the date of your death provided:

1. you are insured under the Policy on the date of death, and
2. We receive proof of death within two (2) years after the date of death

The amount of insurance payable is based upon the Policyholder's Application, and it is set forth on the Schedule of Benefits.

BENEFICIARY

Your beneficiary designation must be made on a form which We provide or on a form accepted by Us. If you name two or more beneficiaries, payment of proceeds will be apportioned equally unless you had specified otherwise. The Policyholder may not be named as beneficiary.

Unless you provided otherwise, if a beneficiary dies before you, We will divide that beneficiary's share equally between any remaining named beneficiaries.

If no named beneficiary survives you or if you did not designate a beneficiary, We will pay the amount of insurance:

1. to your spouse, if living; if not,
2. in equal shares to your then living natural or adopted children, if any; if none,
3. in equal shares to your father and mother, if living; if not,
4. to your estate.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, We will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent Us from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

If any benefits under this provision are to be paid to your estate, We may pay an amount not greater than $5,000 to any person We consider to be equitably entitled by reason of having incurred funeral or other expenses incident to your death. Any and all payments made by Us shall fully discharge Us in the amount of such payment.

CHANGE OF BENEFICIARY

You may change your beneficiary at any time by completing a change request form, or a form accepted by Us, and sending it to the Policyholder. Your written request for change of beneficiary will not be effective until it is recorded by the Policyholder. After it has been so recorded, it will take effect on the later of the date you signed the change request form or the date you specifically requested. If you die before the change has been recorded, We will not alter any payment that We have already made. Any prior payment shall fully discharge Us from further liability in that amount.

CONVERSION OF LIFE INSURANCE

Conversion if Eligibility Terminates:

You may convert to an individual policy of life insurance if your life insurance, or a portion of it, ceases because:

1. you are no longer employed by the Policyholder; or
2. you are no longer in a class which is eligible for life insurance.

In either of these situations, you may convert all or any portion of your life insurance which was in force at the date of termination.

Conversion if Policy is Terminated or Amended:

You may also convert to an individual policy of life insurance if your life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making him ineligible for life insurance; however, in either of these situations,

you must have been insured under the Policy for at least five (5) years.

The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which you become eligible under this or any other group policy within 31 days after the date your life insurance ceased; or
2. $10,000.

Conditions for Conversion: (amended by form no. FDL1-23-1100)

We must receive written application and the first premium for the individual life insurance policy within 31 days after insurance under the Policy ceases. No evidence of insurability will be required.

The individual policy will be a policy of whole life insurance. It will not contain disability benefits, accidental death and dismemberment benefits or any other supplemental benefits.

The premium for the individual policy will be based on:

1. Our current rates based upon your attained age on your nearest birthday; and
2. on the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which you could apply for conversion. If you die during a period when you would have been entitled to have an individual policy issued to you and if you die before such an individual policy becomes effective, We will pay your beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. your death occurred during the 31-day period within which you could have made application; and
2. We receive proof of death within two (2) years of the date of death.

If life insurance benefits are paid under the Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

WAIVER OF PREMIUM

We will continue your life insurance benefit under the Policy without the further payment of life insurance premium if you become Totally Disabled, provided:

1. you are insured under the Policy and are Actively at Work on or after the effective date of the Policy; and
2. you are under the age of 60; and
3. you provide Us with satisfactory written proof of Total Disability within 12 months after the date you became Totally Disabled; and
4. your Total Disability has continued without interruption for at least 6 months; and
5. you are still Totally Disabled when you submit the proof of disability; and
6. all required premium has been paid.

The premium will be waived from the date We receive satisfactory written proof of Total Disability. Premium will continue to be waived provided you:

1. remain Totally Disabled; and
2. provide satisfactory written proof of continuing Total Disability upon request. You are responsible for obtaining initial and continuing proof of disability.

You will be covered for the amount of life insurance in force as of the date Total Disability commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as a result of age or amendment to the Policy. This life insurance coverage will continue without the payment of premium until you are no longer Totally Disabled or reach age 65, whichever occurs first.

We may have you examined at reasonable intervals during the period of claimed Total Disability. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if you refuse to be examined as and when required.

We will pay the amount of life insurance in force to your beneficiary if you die before furnishing satisfactory proof of Total Disability, provided:

1. you die within one year from the date you became Totally Disabled; and
2. We receive proof that you were continuously Totally Disabled until the date of death; and
3. We receive proof of death not more than two (2) years after your death.

If continuation of life insurance under the Waiver of Premium provision ceases, and you are employed by the Policyholder, your life insurance will continue provided premium payments begin on the next premium due date.

If continuation of life insurance under the Waiver of Premium provision ceases, and you are no longer employed by the Policyholder, you may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of the Policy.

ACCELERATED DEATH - TERMINAL ILLNESS BENEFIT

The benefit paid under this provision may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you or your beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect your eligibility for Medicaid or other governmental benefits or entitlements.

ELIGIBILITY

This benefit only applies to you if your life insurance benefit equals $15,000 or more.

Coverage under the Accelerated Death - Terminal Illness Benefit is subject to the Deferred Effective Date provision. You must be Actively at Work on the date your coverage under this benefit becomes effective. If you are not Actively at Work, the effective date of this coverage will be deferred until the first day you return to Active Work.

BENEFIT

The benefit is 50% of your group term life insurance amount in force on the date that We receive Proof that you are Terminally Ill. This sum is limited to a maximum of $150,000 and a minimum of $7,500 and is payable only once to any one Insured.

If your group term life insurance will reduce, due to age, within 12 months after the date We receive Proof, the benefit will be 50% of the reduced group term life insurance benefit.

This benefit does not apply to Accidental Death and Dismemberment benefits.

BENEFIT PAYMENT

We will pay the benefit during your lifetime if you are Terminally Ill if you or your legal representative elects the Benefit and provides satisfactory Proof. The benefit will be paid in one sum to you.

EXCEPTIONS

The benefit will not be payable:

1. for any amount of group term life insurance which is less than $15,000; or
2. if you become Terminally Ill as a result of:
    a. attempted suicide, while sane or insane; or
    b. self-inflicted injury; or
3. if your group term life insurance benefit has been assigned; or
4. if your group term life insurance benefit is payable to an irrevocable beneficiary, including notification to Us that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement.

NOTICE AND PROOF OF CLAIM

You must elect the benefit in writing on a form that is acceptable to Us. You must furnish Proof that you are Terminally Ill, including certification by a Medical Provider.

EFFECT ON INSURANCE

The benefit is in lieu of the group term life insurance benefit that would have been paid upon your death.

When the benefit is paid:

1. the amount of group term life insurance otherwise payable upon your death will be reduced by the benefit;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the benefit; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the benefit.

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFIT AMENDATORY RIDER (NC)

This Rider is made part of the Policy or Certificate to which it is attached. This Rider amends the Section entitled "Accidental Death, Dismemberment and Loss of Sight Benefit" and is subject to all the provisions of the Policy not in conflict with the provisions of this Rider.

If, while insured under this Policy, an Insured suffers an Injury in an Accident, We will pay for those Losses set forth in the subsection entitled "Table of Losses" below. The amount paid will be as stated in the Table of Losses but not more than the Principal Sum set forth in the Application. The Loss must:

1. occur within 365 days of the Accident; and
2. be the direct and sole result of the Accident; and
3. be independent of all other causes.

TABLE OF LOSSES

Principal Sum for Loss of:	**One-half of the Principal Sum for Loss of:**	**One-Quarter the Principal Sum for Loss of:**
Life	Sight of One Eye	Thumb and Index Finger of Same Hand
Both Hands	One Hand	
Both Feet	One Foot	
One Hand and One Foot	Speech or Hearing	
Speech and Hearing		
Sight of Both Eyes		
One Hand and the Sight of One Eye		
One Foot and the Sight of One Eye		

With respect to hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

The total amount of AD&D benefits payable for all Losses for any Insured resulting from any one Accident will not be greater than the Principal Sum set forth in the Application.

Except as provided in a particular benefit, We will pay benefits for Loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other Losses will be paid to the Insured.

SEAT BELT BENEFIT

We will pay an additional benefit, the Seat Belt Benefit, of the lesser of the Insured's Principal Sum or $25,000 if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile, if:

1. the automobile is equipped with Seat Belts;
2. the Seat Belt was in actual use and properly fastened at the time of the Accident;
3. the position of the Seat Belt is certified in the official report of the Accident or by the investigating officer. A copy of the police Accident report must be submitted with the claim; and
4. the Insured was driving or riding in an automobile driven by a licensed driver who was neither:

a. intoxicated or driving while impaired. Intoxication and impairment shall be determined by the law of the jurisdiction in which the Accident occurs, with or without conviction; nor
b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance, taken or inhaled voluntarily, unless as prescribed by a licensed physician and used in the manner prescribed. Controlled substance shall have the meaning as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended. Conviction is not necessary for a determination of being under the influence.

If such certification is not available and if it is unclear whether the Insured was properly wearing a Seat Belt, then We will pay an additional benefit of $1,000.

Seat Belt means those belts that form an occupant restraint system.

AIR BAG BENEFIT

We will pay an additional benefit, the Air Bag Benefit, equal to 5% of the Principal Sum of the AD&D Benefit if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life as the result of an Accident which occurs while the Insured is driving or riding in an automobile provided that:

1. the Insured was positioned in a seat that was equipped with a factory-installed Air Bag;
2. the Insured was properly strapped in the Seat Belt when the Air Bag inflated; and
3. the police report establishes that the Air Bag inflated properly upon impact.

The maximum Air Bag Benefit payable is $5,000.00. If it is unclear whether the Insured was properly wearing Seat Belt(s) or if it is unclear whether the Air Bag inflated properly, then the Air Bag Benefit will be $1,000.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

REPATRIATION BENEFIT

We will pay an additional benefit, the Repatriation Benefit, of up to $5,000 of the Principal Sum of the AD&D Benefit for the preparation and transportation of an Insured's body to a mortuary if:

1. the Principal Sum under the AD&D Benefit is payable for Loss of the Insured's life; and
2. the Insured's death occurs at least 75 miles away from the Insured's principal residence.

EDUCATION BENEFIT

We will pay an additional benefit, the Education Benefit, to the Insured Employee's Dependent Student if the Principal Sum under the AD&D Benefit is payable for Loss of the Insured Employee's life.

Definitions which apply to the Education Benefit:

Student means a Dependent Child who, on the date of the Insured Employee's death, is:

1. A full-time post-high school student in a school of higher education; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a school of higher education within 365 days after the Insured Employee's death.

School of higher education means an institution which:

1. is legally authorized by the State in which it is located; and
2. provides either a program for:
   a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or

b. Gainful employment as long as such program is at least one year of training; and

3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

Eligible Dependent Child means any unmarried child of the Insured (whether natural, step, foster or adopted) who is:

1. at least 15 days but less than 18 years of age and dependent on the Insured for support and maintenance; and
2. not in active military service.

Eligibility will continue to age 23 for Dependent Children who are not employed full-time and are enrolled as a full-time student in a recognized school and dependent on the Insured Employee for support and maintenance.

Eligibility will continue past the age limit for Dependent Children who are primarily dependent upon the Insured for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request.

Note: No eligible person may be covered more than once under this Policy. If a person is covered as an Employee, he cannot be covered as a Spouse or Dependent Child of another Employee.

Amount of Benefit: The maximum Dependent Education Benefit for each dependent Student shall equal the lesser of the Insured Employee's Principal Sum or $12,000.

Payment of Benefit: We will pay the Dependent Education Benefit in four equal annual installments. We will only pay one Dependent Education Benefit to any one dependent Student during any one school year. If the dependent Student is a minor, We will pay the benefit to the legal representative of the minor.

When Benefit Ends: A dependent Student will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:

1. Our payment of the fourth installment of the Dependent Education Benefit on behalf of or to the dependent Student; or
2. At the end of the period during which Due Proof must be submitted if no Due Proof is submitted.

Special Child Education Benefit: If the Insured Employee's Eligible Dependent Child does not qualify as a Student, but is enrolled in an elementary or high school, We will pay a Child Education Benefit in the amount of $1,000. This benefit is payable once upon proof that the Insured Employee has died as a result of an accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after the Insured Employee's death, the Insured Employee's Eligible Dependent Child is a full-time student in an elementary or high school.

LIMITATIONS

We will not pay any benefit for any Loss that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. bacterial infection, except bacterial infection which occurs through an Accidental cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted Accident; or
5. war, declared or undeclared, whether or not the Insured is a member of any armed forces; or
6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance, taken or inhaled voluntarily, unless as prescribed by the Insured's licensed physician and used in the manner prescribed. Controlled substance shall have the meaning as defined in Title II of the

Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended. Conviction is not necessary for a determination of being under the influence; or

9. intoxication as defined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

NOTICE OF CLAIM

If an Insured incurs a loss that may result in a claim for benefits under this Policy, written notice must be given to Us at Our administrative office. This must be done within 20 days after the covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice must contain enough information to identify the claimant.

CLAIM FORMS

When We receive written notice of a claim, We will send the claimant forms with which to file proof of loss. If these forms are not given to the claimant within 15 days, he will be excused from filing the forms provided he sends Us written proof of loss detailing the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS

We must receive written proof of loss within 180 days after the date of the loss for which claim was made. If it can be shown that it was not reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible, failure to furnish proof of loss within 180 days will not invalidate or reduce any claim. However, except in the absence of legal capacity, proof of loss must be furnished no later than one (1) year from the date such proof is required.

For the Education Benefit, Proof of Loss must:

1. Include proof of dependent Student status; and
2. Be submitted no later than
   a. Two months after completion of course work for that particular school year if the dependent Student is enrolled in a school of higher learning at the time of the Insured's death. School year shall be deemed to begin on September 1st and end on August 31st; or
   b. Within six (6) months after enrollment in a school of higher learning if the dependent Student is in the 12th grade at the time of the Insured's death.

   After the first year in a school of higher learning, due proof must be submitted in accordance with the time limits defined in Item (a) above.

PHYSICAL EXAMINATION/AUTOPSY

Upon receipt of a claim, We may examine an Insured, at Our expense, at any reasonable time. We reserve the right to perform an autopsy, at Our expense, if it is not prohibited by any applicable local law(s).

LEGAL ACTION

No action at law or in equity may begin prior to 60 days after We receive valid written proof of loss. No such action may begin after 3 years from the day written proof of loss was required.

(Amended by FDL1-504AD-1002(NC))

PREMIUM AND TERMINATION PROVISIONS (NC)

PREMIUM PROVISION

This provision applies to you only if all or a portion of your group insurance is Contributory. Premiums are payable in United States dollars on or before their due dates. Your Employer has agreed to deduct from your pay your portion of any premium payable for insurance on you or your dependent(s). Your Employer has agreed to remit such premium for the entire time your coverage under the Policy is in effect.

We will allow a grace period of 31 days for the payment of each premium after the first premium. During the grace period, coverage will continue to be in force.

We will charge the rates set forth in the Policy until the first anniversary of the Policy. However, these rates may be changed on any premium due date if Policy provisions or benefits are changed. Following the first Policy Anniversary, We may change rates on any premium due date, but not more than once in any 12 month period. We will notify the Policyholder in writing at least 45 days prior to a change in rates.

TERMINATION PROVISIONS

Termination of the Policy under any conditions will not prejudice any claim which is incurred while the Policy is in force.

TERMINATION OF EMPLOYEE COVERAGE

Your insurance coverage will end on the earliest of:

1. the date you are no longer a member of a covered class; or
2. the date the Policy is canceled or, if applicable, the date the Participating Employer's participation terminates; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which you belong;
4. the date you stop making any required contribution toward payment of premiums; or
5. the date you are no longer Actively at Work; however,

if you are no longer Actively at Work as a result of a disability, layoff, or leave of absence, you may continue to be eligible for group insurance coverage, except short term disability coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, provided all premiums are paid when due.
Leave of Absence	Until the end of the month following the month in which the leave of absence began, provided all premiums are paid when due; or governed by the Employer's Human Resource policy on family and medical leaves of absence, for up to 12 weeks during a leave of absence elected under the federal Family and Medical Leave Act of 1993, provided the leave of absence was approved in advance and in writing by the Employer and all premiums are paid when due.

GENERAL PROVISIONS (NC)

ENTIRE CONTRACT

The Policy, the Application and the enrollment forms of the Insureds are considered to be the entire contract.

STATEMENTS

We consider any statements made by You, in the absence of fraud, to be representations and not warranties. No such statement shall be used in defense to a claim under the Policy unless it is contained in a written application.

INCONTESTABILITY

We will not contest the validity of the Policy, except for nonpayment of premium, after it has been in force for two (2) years from its effective date. We will not contest the validity of your insurance after your insurance has been in force for two (2) years during your lifetime.

MISSTATEMENT OF AGE

If you misstated your age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

CONFORMITY WITH STATE LAW

If any part of the Policy does not conform to a state statute in the state in which it is issued or delivered, it is amended to conform with the minimum requirements of the statutes of that state.

ASSIGNMENT

You may assign the life insurance benefits under the Policy, and you may assign to anyone other than the Policyholder any incident of ownership you may possess. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

RETENTION OF DISCRETION

Fort Dearborn Life Insurance Company shall have the exclusive right to interpret the terms of the Certificate, Schedule of Benefits, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of Fort Dearborn Life and such decisions shall be final and conclusive.

GOODS/SERVICES

From time to time We may offer or provide certain persons who apply for coverage, become Insureds with Us, with prescription discount cards, vision cards, medical identification cards, third party discounts – goods/services. In addition, We may arrange for certain third party providers, e.g. pharmacies, optometrists, dentists, and accountants, to provide goods/services to Our applicants, Insureds. While We have arranged these goods/services,. the providers of the goods/services are liable to the applicants, Insureds for the provision of such goods/services. We are not responsible for the provision of such goods/services nor are we liable for the failure of the provision of the same. Further, We are not liable to the applicants, Insureds for the negligent provision of such goods/services.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.
Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605

North Carolina Department of Insurance, Consumer Division
Post Office Box 26387
Raleigh, North Carolina 27611

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. Following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another area.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
  the insurer was not authorized to do business in this state;
  their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
  interest rate yields that exceed the average rate specified in the law;
  dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one individual, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. For any one group holder of an unallocated annuity contract, the association will pay a maximum of $5,000,000.

FORT DEARBORN LIFE INSURANCE COMPANY

NORTH CAROLINA CERTIFICATE NOTICE REQUIREMENT

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40 NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NON-RENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS PRIOR TO THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

*ERISA INFORMATION STATEMENT

The benefits described in your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Fort Dearborn Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the Effective Date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from, this SPD.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Fort Dearborn Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

B. CLAIMS PROCEDURE

*Disability Insurance Plans

*(Applies to the Waiver of Premium based on disability in Life Certificates).

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist Fort Dearborn in the claims processing for this Plan or by contacting Fort Dearborn directly at:

Claims Department
Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

Fort Dearborn will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, Fort Dearborn notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and

- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a) request a review upon written application within 180 days of the claim denial;
b) request, free of charge, copies of all documents, records and other information relevant to your claim; and
c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Fort Dearborn will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Fort Dearborn notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Fort Dearborn no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;

- the Policy provisions on which the denial is based;

- an explanation of what other information, if any, may be needed to process the claim and why it is needed;

- the steps that you have to follow to have the claim reviewed;

- a statement of your right to bring a civil action on denial of your appeal.

Any denied claim may be appealed to Fort Dearborn for a full and fair review. You may:

a) request a review upon written application within 60 days of receipt of claim denial;
b) review pertinent documents; and
c) submit issues and comments in writing.

A decision will be made by Fort Dearborn no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

C. ERISA NOTICE OF YOUR RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.

FORT DEARBORN LIFE INSURANCE COMPANY

Administrative Office:
1020 31st Street • Downers Grove, Illinois 60515-5591