The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

Group Policyholder: Transport Workers Union of America – Air Transport Division

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on February 1, 2015, and on the same day every four weeks after that. Policy anniversaries will be each January 1; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

This Policy is delivered in the State of District Of Columbia.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is January 1, 2015.

Secretary

President

THIS IS A LEGAL CONTRACT BETWEEN THE POLICYHOLDER AND THE COMPANY. READ YOUR POLICY CAREFULLY.

LIMITED BENEFIT, PLEASE READ CAREFULLY

This is a limited benefit policy. It provides Critical Illness insurance coverage. There is no coverage for hospital, medical-surgical or major medical expenses.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS POLICY CONTAINS A PRE-EXISTING CONDITION EXCLUSION.

GROUP CRITICAL ILLNESS INSURANCE POLICY
No. GL 0000TWUATDCI00000

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

CLASSIFICATION

Class 1	All Members in Good Standing of Transport Workers Union of America – Air Transport Division

ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section):

For Class 1: None

ANNUAL/OPEN ENROLLMENT PERIOD: November 1 – December 1

BENEFITS FOR CLASS 1

ELIGIBLE CLASS means: All Members in Good Standing of Transport Workers Union of America – Air Transport Division

CONTRIBUTIONS: Insured Persons are required to contribute to the cost for Personal Critical Illness Insurance. Insured Persons are required to contribute to the cost for Dependent Critical Illness Insurance.

PERSONAL CRITICAL ILLNESS INSURANCE

Class 1 (Option as elected by the Insured Person)	Personal Critical Illness Principal Sum
Option 1	$5,000
Option 2	$10,000
Option 3	$15,000
Option 4	$20,000
Option 5	$25,000
Option 6	$30,000

DEPENDENT CRITICAL ILLNESS INSURANCE
(For Class 1)

Dependent Spouse (Option as elected by the Insured Person)	Dependent Critical Illness Principal Sum
Option 1	$5,000
Option 2	$10,000
Option 3	$15,000

Dependent Child (Option as elected by the Insured Person)	
Option 1	$5,000

HEART CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
Heart Attack	100%
Placement on United Network for Organ Sharing (UNOS) List for Heart Transplant*	100%
Stroke	100%
Arteriosclerosis	10%, subject to a lifetime maximum of 2 payments
Aneurysm due to Arteriosclerosis	10%, subject to a lifetime maximum of 2 payments

CANCER CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
Cancer	100%
Cancer in Situ	25%
Benign Brain Tumor	25%
Placement on the Be the Match Registry for Bone Marrow Transplant*	25%

ORGAN CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
End Stage Renal Failure	100%
Placement on United Network for Organ Sharing (UNOS) List for Major Organ Transplant (excluding Heart)*	100%
Acute Respiratory Distress Syndrome	25%

WELLNESS CATEGORY (Available for Insured Persons and Dependents)

Critical Illness Assessment Benefit

Critical Illness Assessment Period:	January 1st through December 31st
Critical Illness Assessment Benefit:	$50 for each Critical Illness Assessment Test performed, subject to a maximum of 1 Critical Illness Assessment Test per person per Critical Illness Assessment Period

Child Care Expense Benefit $25 per Child per day

For each Insured Person or Insured Dependent, the lifetime total benefits payable in any category shown in the Schedule of Benefits (except the Wellness Category) are subject to an overall maximum of 100% of the Principal Sum.

*A benefit for this Event may also be payable if an Insured Person or Insured Dependent:
(1) is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the network/registry; or
(2) receives a transplant prior to placement on the network/registry.

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted when:
(1) Critical Illness Insurance amounts exceed the guarantee issue amount of $30,000 for Insured Persons or $15,000 for Insured Dependent Spouses at initial enrollment;
(2) the amount of Critical Illness Insurance increases after the initial enrollment; or
(3) initial coverage is elected more than 31 days after first becoming eligible.

DEFINITIONS

ACTIVE MEMBER means a dues paying member in good standing of the Group Policyholder.

ACUTE RESPIRATORY DISTRESS SYNDROME means acute respiratory failure resulting in inadequate oxygenation, due to aspiration or infection. Diagnosis is determined by a Physician and based on:

(1) demonstration of infiltrates in both lungs in the absence of clinical heart failure; and
(2) acute lung injury demonstrated by testing of blood gases.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANEURYSM DUE TO ARTERIOSCLEROSIS means an abnormal widening or ballooning of a portion of an artery due to weakness of the arterial wall caused by Arteriosclerosis, of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Aneurysm is diagnosed by a Physician based on arteriography or other appropriate imaging studies.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible members to purchase or make changes to their Personal or Dependent Critical Illness Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

ARTERIOSCLEROSIS means blockage of a coronary artery of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Diagnosis is made by a board-certified or board-eligible cardiologist and is accompanied by the demonstrated need for intervention.

BENIGN BRAIN TUMOR means a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. Diagnosis of the tumor and neurological deficit must be confirmed by imaging and examination findings conducted by a board-certified or board-eligible neurologist or other Physician appropriately licensed to diagnose the deficit.

BONE MARROW TRANSPLANT means a transplant necessitated by a compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis is made by a board-certified or board-eligible hematologist or board-certified or board-eligible oncologist who determines that the bone marrow transplant is necessary and places the Insured Person or Insured Dependent on the Be The Match registry. If the Insured Person or Insured Dependent is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the registry; the registry requirement will be waived. The registry requirement will also be waived if the Insured Person or Insured Dependent receives the transplant prior to placement on the registry.

CANCER means malignant cells or tumors characterized by uncontrolled growth with spread beyond the initial tissue. Diagnosis must be by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic tissue evaluation (biopsy). The following are not considered Cancer for purposes of this definition:

(1) Cancer in Situ;
(2) basal cell carcinoma and squamous cell carcinoma of the skin; and
(3) melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm.

CANCER IN SITU means Cancer cells confined to the surface tissues (epithelium) without invasion of the basement membrane and with no spread to regional lymph nodes or other tissues. Diagnosis is made by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic examination of tissue (biopsy). Basal cell and squamous cell carcinomas of the skin are not considered Cancer in Situ.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DEPENDENT CRITICAL ILLNESS INSURANCE means the coverage provided by this Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the period of time a Person must be in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for insurance under this Policy.

END STAGE RENAL FAILURE means chronic and irreversible failure of the kidneys of such magnitude that permanent dialysis or transplant is required to sustain life.

EVENT/ILLNESS means a Critical Illness event or illness:
(1) shown in the Schedule of Benefits; and
(2) for which the Insured Person or Insured Dependent is covered under this Policy.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of this Policy.

HEART ATTACK (MYOCARDIAL INFARCTION) means death of a portion of heart muscle due to inadequate circulation in coronary arteries. If no death of heart muscle occurs, this is not considered a heart attack. Diagnosis is made by a board-certified or board-eligible cardiologist and based on findings from an electrocardiogram (EKG) and elevation of cardiac enzymes associated with heart attack.

HEART TRANSPLANT means the transplantation of a healthy heart from a suitable donor, necessitated by the diagnosis of end-stage heart disease, as determined by a Physician appropriately specialized for the heart. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person or Insured Dependent is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person or Insured Dependent receives the transplant prior to placement on the network.

HOSPITAL means a general hospital which:

(1) is licensed, approved or certified by the state where it is located;
(2) is recognized by the Joint Commission;
(3) is operated to treat Inpatients;
(4) has a registered nurse always on duty; and
(5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

(1) is specialized solely in dentistry, mental illness or substance abuse;
(2) is a rest home, home for the aged, convalescent home or nursing home; or
(3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

INPATIENT means an Insured Person or Insured Dependent who is an overnight resident patient.

INSURANCE MONTH means that period of time:
(1) beginning at 12:01 a.m. on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month;
at the Group Policyholder's primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED DEPENDENT SPOUSE means the Insured Person's spouse for whom coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAJOR ORGAN means the liver, lungs, pancreas, intestines, or combinations of these organs.

MAJOR ORGAN TRANSPLANT means the transplantation of a healthy Major Organ from a suitable donor, necessitated by the diagnosis of end-stage organ disease (organ failure), as determined by a Physician appropriately specialized for the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person or Insured Dependent is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person or Insured Dependent receives the transplant prior to placement on the network.

PERSON means a member of the Group Policyholder:
(1) who is a member of a class that is eligible for insurance under this Policy; and
(2) who has completed an enrollment form.

PERSONAL CRITICAL ILLNESS INSURANCE means the insurance provided by this Policy for Insured Persons.

PHYSICIAN means:

(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or

(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does not include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

(1) the Insured Person's spouse, siblings, parents, children and grandparents; and

(2) his or her spouse's relatives of like degree.

POLICY means this Group Critical Illness Insurance policy issued by the Company to the Group Policyholder.

PREMIUM means the amount charged for insurance coverage.

STROKE means permanent neurological damage to the brain due to inadequate blood flow in any of the cranial vessels, due to either blockage or rupture of the vessel and categorized as Score 3 on the Modified Rankin Scale. Diagnosis of permanent neurological damage should be made by a neurologist and demonstrated by imaging (CT or MRI) and examination demonstrating lasting neurological deficits (motor, cognitive, or sensory). Transient Ischemic Attacks (TIA) are not considered Strokes.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:
(1) this Policy and any amendments to it; and
(2) the Group Policyholder's application.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons or Insured Dependents are representations and not warranties. No statement made by an Insured Person or Insured Dependent will be used to contest the insurance provided by this Policy, unless:
(1) it is contained in a written statement signed by that Insured Person or Insured Dependent; and
(2) a copy of the statement has been furnished to that Insured Person or Insured Dependent.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:
(1) determine the insurability of a group or any individual within a group;
(2) make a contract in the Company's name;
(3) amend or waive any provision of this Policy; or
(4) extend the time for payment of any premium.
No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Person or Insured Dependent, after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) this Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of insurance.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) an Insured Person or Insured Dependent incurs a claim during the first two years of coverage; and
(2) the Company discovers that the Insured Person or Insured Dependent made a Material Misrepresentation on his or her application.

A "**Material Misrepresentation**" is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. "**To rescind**" means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for Insured Person's or Insured Dependent's claims. The Company reserves the right to recover any claims paid in excess of such premiums.

NONPARTICIPATION. This is a non-participating policy. It will not share in the divisible surplus of any Company.

INFORMATION TO BE FURNISHED. The Group Policyholder may be required to furnish any information needed to administer this Policy, including:

(1) information about persons:
  (a) who become eligible for insurance;
  (b) whose amounts of insurance change; or
  (c) whose eligibility or insurance ends;
(2) occupational information and other facts that may be needed to manage a claim; and
(3) any other information that the Company may reasonably require.

The Company may inspect the Group Policyholder's records that relate to this Policy, at any reasonable time.

Clerical error by the Group Policyholder or any Participating Organization:

(1) will not void or terminate insurance that otherwise would be in effect;
(2) will not result in insurance coverage that otherwise would not be in effect; and
(3) will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof such an adjustment should be made.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person or Insured Dependent were misstated:

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

If any Insured Person's or Insured Dependent's age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

ACTS OF THE POLICYHOLDER. In administering this Policy, the Group Policyholder must:

(1) treat members the same in like situations; and
(2) allow the Company, without inquiry, to rely on its acts.

GROUP POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CERTIFICATES. The Group Policyholder will be furnished with individual certificates of insurance for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:

(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE

ELIGIBILITY. A Person becomes eligible for insurance provided by this Policy on the later:

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed (For Waiting Period, see Schedule of Benefits).

ENROLLMENT. A Person may enroll for Personal Critical Illness Insurance only:

(1) when first eligible; or
(2) during any Annual/Open Enrollment Period.

EFFECTIVE DATE. Personal Critical Illness Insurance becomes effective on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the day the Person becomes eligible for the insurance;
(2) the date following the Person's discharge from the facility, if the Person is confined to a hospital or other health care facility on the day coverage would otherwise become effective; or
(3) if the Person contributes to the cost of the Personal Critical Illness Insurance, the date the Person makes written application for insurance and pays the required premium to the Company.

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date on which the Insured Person becomes eligible for the increase;
(2) the day of the Insurance Month coinciding with or next following the Person’s final discharge from a hospital or other health care facility, if he or she is confined to such a facility on the date the increase would otherwise take effect; or
(3) the day the Person’s resumption of the normal activities of a healthy person of the same age and sex, if he or she is in a Period of Limited Activity and unable to perform such activities on the date the increase would otherwise take effect.

Any reduction in insurance or benefits will take effect on the day of the change.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE (Continued)

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Personal Critical Illness Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period (See Schedule of Benefits).

TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE

TERMINATION. An Insured Person's insurance will terminate at 12:00 midnight on the earliest of:

(1) the date this Policy terminates (but without prejudice to any claim incurred prior to termination);
(2) the date the Insured Person's Class is no longer eligible for insurance;
(3) the date the Insured Person ceases to be a member of the Eligible Class;
(4) the last day of the Insurance Month in which the Insured Person requests termination;
(5) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of this Policy providing that type of benefit terminates;
(8) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category;
(9) the date the Insured Person ceases to be covered under at least one category other than the Wellness Category;
(10) the date the Insured Person's membership with the Group Policyholder or Participating Organization terminates; or
(11) the date the Insured Person enters armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If the Person sends proof of military service, the Company will refund any unearned premium.)

PORTABILITY. If insurance under this Policy would end for any reason other than nonpayment of premiums, the Insured Person has the option to continue Personal Critical Illness Insurance and Dependent Critical Illness Insurance. To continue insurance under this section, the Insured Person must:

(1) notify the Company within 31 days of the date the insurance would otherwise end; and
(2) pay the applicable premium to the Company.

A direct billing fee will apply when insurance is continued in accord with the Portability provision. This fee will be based on the billing frequency chosen.

Portability is not available when insurance terminates solely because an Insured Person's spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

(1) the last day of the period for which the Insured Person paid premiums; or
(2) the date the Company receives a written request from the Insured Person to terminate the insurance; or
(3) the date the Insured Person attains age 90, or dies.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for claims incurred by the Insured Person while he or she was insured under this Policy.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE

DEPENDENT means an Insured Person's:

(1) legal spouse, who is not legally separated from the Insured Person;
(2) child less than 26 years of age; or
(3) child age 26 years or older, who is:
    (a) continuously unable to earn a living because of a physical or mental disability; and
    (b) chiefly dependent upon the Insured Person for support and maintenance.

    The child must be covered by the Group Policyholder's Critical Illness plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:
    (a) within 31 days of the day insurance would otherwise end due to age; and
    (b) thereafter, when the Company requests (but not more than once every two years).

Dependent will also include a child that is required to be provided insurance by the Insured Person under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

"Child" includes:

(1) an Insured Person's natural child, legally adopted child, or stepchild;
(2) a child placed with the Insured Person for the purpose of adoption, from the date of placement;
(3) a child for whom the Insured Person is required by court order to provide Critical Illness insurance;
(4) a grandchild who resides in the Insured Person's household; and who is chiefly dependent on the Insured Person for support;
(5) a child of a civil union partner or domestic partner; and
(6) a foster child for whom the Insured Person has assumed full parental responsibility and control.

ELIGIBILITY. An Insured Person becomes eligible to enroll for Dependent Critical Illness Insurance on the latest of:

(1) the date the Insured Person becomes eligible for Personal Critical Illness Insurance;
(2) the issue date of this Policy; or
(3) the date the Insured Person first acquires a Dependent.

An Insured Person again becomes eligible to enroll for Dependent Critical Illness Insurance under this Policy during any Annual/Open Enrollment Period.

A Person must be insured for Personal Critical Illness Insurance to insure his or her Dependents. Dependents to be insured by this Policy must be enrolled in and approved for the same plan of benefits as the Insured Person.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE (Continued)

ANNUAL/OPEN ENROLLMENT PERIOD. A Person again becomes eligible to enroll, re-enroll, or change benefit options for Dependent Critical Illness Insurance under this Policy during the Group Policyholder's Annual/Open Enrollment Period.

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Critical Illness Insurance will become effective on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date the Insured Person becomes eligible for Dependent Critical Illness Insurance; or
(2) the first day of the Insurance Month following the date the Insured Person makes written application for Dependent Critical Illness Insurance and pays the required Dependent premium to the Company; or
(3) the first day of the Insurance Month following the date the Company approves any Evidence of Insurability, if required (See Schedule of Benefits).

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires the Insured Person to provide Critical Illness benefits for the child, the insurance will become effective on the date stated in the court order; subject to:

(1) any eligibility and Evidence of Insurability requirements set forth in this Policy; and
(2) payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

(1) the Insured Person completes a written application; and
(2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If an Insured Person acquires a newborn Dependent child, the child will be automatically insured for the first 31 days following birth. If the Insured Person elects not to enroll the newborn child and pay any additional premium within 31 days following birth, the newborn child's insurance will terminate.

TERMINATION OF DEPENDENT CRITICAL ILLNESS INSURANCE

TERMINATION. Critical Illness Insurance on a Dependent will cease on the earliest of:

(1) the date he or she ceases to be an eligible Dependent, as defined in this Policy;
(2) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category; or
(3) the date he or she ceases to be covered under at least one category other than the Wellness Category.

Dependent Critical Illness Insurance will cease for all of the Insured Person's Dependents on the earliest of:

(1) the date the Insured Person's Critical Illness Insurance terminates;
(2) the date Dependent Critical Illness Insurance is discontinued under this Policy;
(3) the date the Insured Person ceases to be in a class eligible for Dependent Critical Illness Insurance;
(4) the date the Insured Person requests that the Dependent Critical Illness Insurance be terminated;
(5) with respect to a benefit or a specific type of benefit, the date the portion of this Policy providing that type of benefit terminates; or
(6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Critical Illness Insurance terminates due to the Insured Person's death, Dependent Critical Illness Insurance may be continued:

(1) for three Insurance Months; or any longer period, if required by state or federal law;
(2) provided the Group Policyholder submits the premium on behalf of the surviving Dependents; and this Policy remains in force.

REINSTATEMENT OF DEPENDENT INSURANCE If an Insured Person reinstates his or her Personal Critical Illness Insurance, the Insured Person may also reinstate Dependent's Critical Illness Insurance at the same time. To do so, the Insured Person must follow the same requirements that apply in the reinstatement of the Insured Person's Personal Critical Illness Insurance.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for claims incurred by the Insured Dependent while he or she was insured under this Policy.

PREMIUM AND PREMIUM RATES

PAYMENT OF PREMIUMS. No insurance provided by this Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due.

GRACE PERIOD. A grace period of 60 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period, unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

PREMIUM RATE CHANGE. The Company may change any premium rate:

(1) the date this Policy's terms are changed;
(2) the date the Company's liability is changed due to a change in federal, state or local law;
(3) the date the Company's liability is changed because the Group Policyholder (or any covered division, subsidiary or affiliated company) relocates, dissolves or merges, or is added to or removed from this Policy; or
(4) on any premium due date after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company, for all policies of like class.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 31 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the sum of the products obtained by multiplying each rate shown in the Premium Rate Schedule by the amount of insurance to which the rate applies.

For premium purposes, the effective date of any change in insurance is the first day of the Insurance Month which coincides with or follows the change. Changes will not be pro-rated daily.

PREMIUM RATE SCHEDULE

Critical Illness Rates

Critical Illness Base Coverage Rates
Class: 1
Class Description: All Full-Time Members of Transport Workers Union – Air Transport Division

Wellness Category

Annual premium rate per $1,000 of Personal Critical Illness Insurance*

Issue Age	Non-Tobacco	Tobacco
17-30	$1.144	$1.144
31-40	$1.144	$1.144
41-50	$1.144	$1.144
51-60	$1.144	$1.144
61-70	$1.144	$1.144

*Same rates apply for Dependent Spouse Critical Illness Insurance.

PREMIUM RATE SCHEDULE (Continued)

Heart Category

Annual premium rate per $1,000 of Personal Critical Illness Insurance*

Issue Age	Non-Tobacco	Tobacco
17-30	$0.884	$1.560
31-40	$2.808	$5.096
41-50	$7.124	$13.520
51-60	$13.364	$25.532
61-70	$23.920	$43.420

*Same rates apply for Dependent Spouse Critical Illness Insurance.

Annual premium rate per $1,000 of Dependent Child(ren) Critical Illness Insurance

Issue Age	Rate
17-30	$0.468
31-40	$0.624
41-50	$0.624
51-60	$0.520
61-70	$0.416

*Child rates based on member's issue age.

Cancer Category

Annual premium rate per $1,000 of Personal Critical Illness Insurance*

Issue Age	Non-Tobacco	Tobacco
17-30	$1.872	$2.288
31-40	$3.640	$5.148
41-50	$7.748	$13.728
51-60	$15.704	$34.008
61-70	$26.676	$63.700

*Same rates apply for Dependent Spouse Critical Illness Insurance.

Annual premium rate per $1,000 of Dependent Child(ren) Critical Illness Insurance

Issue Age	Rate
17-30	$0.832
31-40	$1.092
41-50	$1.144
51-60	$0.936
61-70	$0.728

*Child rates based on member's issue age.

PREMIUM RATE SCHEDULE (Continued)

Organ Category

Annual premium rate per $1,000 of Personal Critical Illness Insurance*

Issue Age	Non-Tobacco	Tobacco
17-30	$0.780	$1.196
31-40	$1.040	$1.768
41-50	$1.300	$2.496
51-60	$1.820	$3.380
61-70	$2.132	$4.108

*Same rates apply for Dependent Spouse Critical Illness Insurance.

Annual premium rate per $1,000 of Dependent Child(ren) Critical Illness Insurance

Issue Age	Rate
17-30	$1.976
31-40	$2.704
41-50	$2.756
51-60	$2.184
61-70	$1.820

*Child rates based on member's issue age.

POLICY TERMINATION

TERMINATION BY THE COMPANY. This Policy is issued for an indefinite term. The Policy will continue in force as long as premiums are paid when due, unless terminated for one of the following reasons:

(1) the Group Policyholder, without good cause, fails to:
   (a) promptly furnish any information which the Company may reasonably require; or
   (b) perform its duties pertaining to this Policy in good faith; or
(2) state law otherwise requires this Policy to be terminated.

To terminate this Policy, the Company must give the Group Policyholder at least 31 days' advance written notice of its intent to do so.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time by giving the Company advance written notice. Insurance will then terminate:

(1) on the date the Company receives the notice; or
(2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

EFFECT ON INCURRED CLAIMS. Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in effect.

CRITICAL ILLNESS BENEFITS
For Class 1

GENERAL CRITICAL ILLNESS BENEFITS. The Company will pay a Critical Illness Benefit if an Insured Person or Insured Dependent sustains an Event/Illness shown in the Schedule of Benefits while covered under this Policy.

Benefit amounts payable are shown in the Schedule of Benefits.

For each Insured Person or Insured Dependent, the lifetime total benefits payable in any category shown in the Schedule of Benefits (except the Wellness Category) are subject to an overall maximum, as shown in the Schedule of Benefits. Certain Events/Illnesses are also subject to separate lifetime maximums, as shown in the Schedule of Benefits. If benefits paid to an Insured Person or Insured Dependent reach the overall maximum for a category, his or her coverage for that category will terminate.

Except for the Wellness Category, benefits are not payable if an Event/Illness shown in the Schedule of Benefits occurs within:

(1) 180 days of another Event/Illness in the same category; or
(2) 90 days of an Event/Illness in a different category.

If the Insured Person or Insured Dependent sustains two or more Events/Illnesses simultaneously, the highest applicable benefit is payable. Certain Events/Illnesses are only payable once per the Insured Person's or Insured Dependent's lifetime, as shown in the Schedule of Benefits.

CRITICAL ILLNESS ASSESSMENT BENEFIT. The Company will pay a Critical Illness Assessment Benefit to an Insured Person or Insured Dependent who has one of the following Critical Illness Assessment Tests:

(1) abdominal aortic aneurysm ultrasound;
(2) blood test for triglycerides;
(3) bone marrow testing;
(4) bone density screening;
(5) breast ultrasound;
(6) CA 15-3 (blood test for breast cancer);
(7) CA125 (blood test for ovarian cancer);
(8) carotid ultrasound;
(9) CEA (blood test for colon cancer);
(10) chest x-ray;
(11) colonoscopy;
(12) CT Angiography;
(13) EKG;
(14) double contrast barium enema;
(15) fasting blood glucose test;
(16) flexible sigmoidoscopy;
(17) hemoccult stool analysis;
(18) mammography;
(19) pap smear;
(20) PSA (blood test for prostate cancer);
(21) serum cholesterol HDL/LDL;
(22) serum protein electrophoresis (blood test for myeloma);
(23) stress test; or
(24) thermography.

The Critical Illness Assessment Test must be performed during the Critical Illness Assessment Period as shown in the Schedule of Benefits, while the Insured Person's or Insured Dependent's coverage under this Policy is in effect. The Critical Illness Assessment Benefit is subject to the maximums shown in the Schedule of Benefits.

CHILD CARE EXPENSE BENEFIT. The Company will pay a Child Care Expense Benefit if an Insured Person or Insured Dependent Spouse incurs Child Care Expenses while confined as an Inpatient in a Hospital or Alternate Care or Rehabilitative Facility for an Event/Illness shown in the Schedule of Benefits.

"Child Care Expense" means an expense for the care of a Child, charged by a licensed care provider who:
(1) is not a member of the Insured Person's immediate family; and
(2) is not living in the Insured Person's home.

"Child," as used in the Child Care Expense Benefit, means the Insured Person's naturally born child, legally adopted child, stepchild, foster child, or child for whom the Insured Person is the legal guardian, if the child is:
(1) less than age 16 and living with the Insured Person; or
(2) age 16 years or older, who is:
    (a) unmarried;
    (b) living with the Insured Person; and
    (c) incapable of independent living due to a mental or physical condition.

Amount. The amount of the Child Care Expense Benefit is shown in the Schedule of Benefits.

Proof. The Insured Person must submit to the Company satisfactory proof that a Child Care Expense has been incurred for a Child (as defined in this provision) and paid by the Insured Person or Insured Dependent Spouse. Satisfactory proof is a signed receipt from the Child care provider showing:
(1) Child name;
(2) Child age;
(3) dates of care;
(4) total charges for care;
(5) total payments for care; and
(6) provider name, address, telephone number, and Federal Employer Identification Number/Taxpayer Identification Number.

Duration. The Child Care Expense Benefit will be payable for up to a maximum of 30 days from the date the Insured Person or Insured Dependent Spouse was confined as an Inpatient in a Hospital. This Benefit will cease on the earliest of:
(1) the date the Insured Person or Insured Dependent Spouse is released from Inpatient treatment;
(2) the date an Insured Person's or Insured Dependent Spouse's Child(ren) no longer meet(s) the definition of Child in this provision; or
(3) the date the maximum duration ends.

EXCLUSIONS
For Class 1

GENERAL EXCLUSIONS. Benefits are not payable for any Event/Illness or loss resulting, directly or indirectly, from or in any degree caused by:

(1) intentional self-inflicted injury, self-destruction, or suicide, or any attempt thereof; whether sane or insane;
(2) participation in, commission of or attempt to commit a felony;
(3) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
(4) duty as a member of any military, including Reserves or National Guard; or
(5) an Event/Illness sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

Benefits are also not payable while an Insured Person or Insured Dependent is incarcerated in any type of penal or detention facility.

PRE-EXISTING CONDITION EXCLUSION. Benefits are not payable for any Event/Illness or loss:

(1) resulting, directly or indirectly, from or in any degree caused by a Pre-Existing Condition; and
(2) diagnosed in the first months following the Insured Person's or Insured Dependent's Effective Date; unless the Insured Person or Insured Dependent receives no Treatment for the Pre-Existing Condition for consecutive months following his or her Effective Date.

"Pre-Existing Condition" means an illness or event for which the Insured Person or Insured Dependent received Treatment within the months prior to his or her Effective Date.

"Treatment" means a Physician's consultation, care or services; diagnostic measures; and the prescription, refill or taking of prescribed drugs or medicines.

The above Pre-Existing Condition Exclusion will also apply to:

(1) any increase in the Critical Illness Principal Sum;
(2) the addition by amendment of a benefit or category of benefits under this Policy;
(3) an Insured Person's election after initial enrollment of any category of benefits under this Policy; and
(4) the election after initial enrollment of any benefit provided by an amendment to this Policy.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At the death of an Insured Person, any amount payable under this Policy will be paid to the named Beneficiary who survives the Insured Person. If the Insured Person has not named a Beneficiary, or if no named Beneficiary survives the Insured Person; then payment will be made to the Insured Person's:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving sibling or siblings in equal shares; or, if none
(5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

(1) within 15 days of the Insured Person's death; and
(2) before the Company receives satisfactory proof of the Insured Person's death;

payment will be made as if the Insured Person had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. An Insured Person's Beneficiary will be as shown on his or her enrollment form, unless changed. If this Policy replaces a group policy providing similar coverages; then an Insured Person's beneficiary named under the prior policy will be the Beneficiary under this Policy, until changed.

CHANGING THE BENEFICIARY. Only the Insured Person or his or her assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office prior to the Insured Person's death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under this Policy becomes payable to an Insured Person's estate, a minor, or any person who is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

(1) a person who has assumed the care and support of the Insured Person or Beneficiary;
(2) a person who has incurred expense as a result of the Insured Person's last illness or death;
(3) the personal representative of the Insured Person's estate; or
(4) any person related by blood or marriage to the Insured Person.

No payment made to anyone named above may exceed $1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

(1) the Group Policyholder's name and Policy number;
(2) the Insured Person's name, address and certificate number, if available; and
(3) the patient's name and relationship to the Insured Person.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then the Person may send the Company written proof of claim in a letter. It should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after a claim is incurred; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

(1) the nature, date and cause of the claim;
(2) a description of the services provided; and
(3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

(1) any study models, treatment records or charts;
(2) copies of any x-rays or other diagnostic materials; and
(3) any other items the Company may reasonably require.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While a Critical Illness claim is pending, the Company may have the claimant examined:

(1) by a Physician of its choice;
(2) as often as is reasonably required.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Critical Illness benefits payable under this Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All benefits payable under this Policy, including any benefits for Insured Dependents, will be paid to the Insured Person, while living, unless:

(1) an overpayment has been made and the Company is entitled to reduce future benefits; or
(2) state or federal law requires that benefits be paid to a Insured Dependent child's custodial parent or custodian.

If any benefits remain to be paid after the Insured Person's death, such benefits will be paid in accord with the Beneficiary provision.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

(1) the reason for the denial, under the terms of this Policy and any internal guidelines;
(2) how the claimant may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of a Critical Illness claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of a Critical Illness claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of a Critical Illness claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

(1) any further appeal procedures available under this Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

For a Critical Illness claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

(1) the Company's error in processing a claim;
(2) the claimant's receipt of benefits or services under another plan;
(3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that this Policy clearly reserves to the Group Policyholder, the Company has the authority to:

(1) manage this Policy and administer claims under it; and
(2) interpret the provisions and to resolve questions arising under this Policy.

The Company's authority includes (but is not limited to) the right to:

(1) establish and enforce procedures for administering this Policy and claims under it;
(2) determine eligibility for insurance and entitlement to benefits;
(3) determine what information the Company reasonably requires to make such decisions; and
(4) resolve all matters when a claim review is requested.

The claimant has the right to:

(1) request a state insurance department review; or
(2) bring legal action.

Summary of General Purposes and Current Limitations of Coverage

Residents of the District of Columbia who purchase health insurance, life insurance and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty 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 the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted on the other side of this page.

Disclaimer

The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner will respond to any question, you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer. Policyholders with additional questions may contact:

Ms. Gennet Purcell
Commissioner
District of Columbia Department
of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

Mr. Robert M. Willis
Executive Director
District of Columbia Life and Health
Insurance Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771
Fax: (202) 347-2990

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. Below is a brief summary of the 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. If you have obtained this document form an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

Coverage

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group insurance contract issued by a member insurer. Beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by the Guaranty 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 of that state of incorporation);
- The insurer was not authorized to do business in the District of Columbia: or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty 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;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Limits on amount of coverage

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- *the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or*
- *with respect to any one life, regardless of the number of policies, contracts, or certificates:*
    - *$300,000 in life insurance death benefits but not more than $100,000 in net cash surrender or net cash withdrawal values for life insurance; or*
    - *$100,000 in health insurance benefits, including net cash surrender or net case withdrawal values; or*
    - *$300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.*

Finally, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

The Lincoln National Life Insurance Company
Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

Office Use Only ID# _____

APPLICATION FOR GROUP INSURANCE

is hereby made to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): Transport Workers Union-Air Transport Division

2. **Main Office Address** (physical location and group situs state):

Street 501 3rd Street NW - 9th Floor City Washington State D.C.

Zip 20001 Phone # (202) 719-3900 FAX # (202) 347-0454 E-Mail Address (if available) _____

B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

- ☐ Life & AD&D with Effective Date _____
- ☐ Long Term Disability with Effective Date _____
- ☐ Short Term Disability with Effective Date _____
- ☐ Dental with Effective Date _____
- ☐ Accident with Effective Date _____
- ☒ Critical Illness with Effective Date 01/01/2015
- ☐ Voluntary Life with Effective Date _____
- ☐ Voluntary Life & AD&D with Effective Date _____
- ☐ Voluntary Long Term Disability with Effective Date _____
- ☐ Voluntary Short Term Disability with Effective Date _____
- ☐ Voluntary Dental with Effective Date _____

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): Labor Union

Years in Business 81 Federal Tax ID# _____

2. **Business is Organized As** (select one):

☐ Corporation ☒ Non-Profit Organization
☐ Partnership ☐ Proprietorship ☐ Other Unincorporated Association

3. **Financial Risk** (If Yes to any part, please explain below.)

☐ Yes ☐ No Has Applicant ever filed for bankruptcy?
☐ Yes ☐ No Does Applicant anticipate ceasing or materially reducing active business operations?
☐ Yes ☐ No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?

Explanation: _____

4. **Binder** payment submitted: Amount $ _____ (if applicable)

D. REPLACEMENT COVERAGE

☐ Yes ☐ No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date

E. FRAUD WARNING

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents a false information in a an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Services.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KENTUCKY: Any person who knowingly and with the intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information containing any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA & RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

OTHER STATES (EXCEPT KANSAS): A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

F. AGREEMENT. The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions and limitations of the Policy; and
(e) take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to any Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent Or Broker's Signature: Union Benefit Planners, Inc.

Typed or Printed Name: Union Benefit Planners, Inc.

License Number: 2894533 State: DC

Signed by Applicant's Authorized Representative:

Signature: [signature]

Typed or Printed Name: Stephen DeBiasi

Title: CEO

State Signed: DC Date: 1/1/15

Must be signed prior to Effective Date