Horace Mann
Founded by Educators for Educators

Horace Mann Life Insurance Company
1 Horace Mann Plaza
Springfield, Illinois 62715-0001
1-800-999-1030
horacemann.com

Policyholder: Burlington School District

Effective date: January 1, 2020

Initial mode of payment: Monthly

Group number: 440111 {Optional Life}

State of delivery: Vermont

Group Term Life Insurance Policy

One Year Renewable Term Insurance – **Contributory insurance**
Non-participating – With a Conversion Option

The **policyholder** has completed the application, a copy of which is attached. The **policyholder** has paid the premium. These actions put the **policy** in force as of the effective date shown above. This means that **we** agree to pay benefits as stated in this **policy** for any person insured.

Life insurance coverage is provided for each **insured** during the period of each term of coverage. This **policy** has no cash values and does not provide cash surrender values. The laws of the State of delivery shown above will govern this **policy**.

The **policy** starts at 12:01 a.m. Standard Time at the address of the **policyholder** on the effective date; and it stays in force for a term of one year. This **policy** can be renewed with **our** consent for another one year term. Each time the **policy** is renewed, the new term starts when the old term ends. **Your** benefits and rights under this **policy** will not be less than those stated in **your** certificate.

This **policy** replaces the original **policy** (Group number 440111) issued effective 1/1/1992 and any subsequent versions **we** may have given to the **policyholder**.

This is a legal contract between the company and the policyholder.

President

Corporate Secretary

Alphabetical table of contents

Schedule of benefits

Class	Amount of insurance
Departments	
2) Teachers with Optional Life	$37,500
5) Department 4 with Optional Life	$37,500
13) Administrators with Optional Life	$37,500
15) Department 14 with Optional Life	$37,500
19) Department 18 with Optional Life	$25,000
22) Department 21 with Optional Life	$37,500

Changes in amount of insurance

Any change in the amount of insurance will become effective on the premium due date on or after the date the **insured** becomes eligible for the change.

If applicable, amounts may change as shown in the Schedule of benefits when an **insured** moves from one classification to another.

The **insured** must be **actively at work** on the date of the change except as outlined in the Waiver of premium provision. If not, the change will not become effective until the premium due date on or after the date the **insured** returns to active work.

Definitions

The terms **we** use in this policy are defined below. When these terms appear elsewhere in this policy, they will be in **bold** print. Any pronouns used in this **policy** will apply to the appropriate gender.

"**Actively at work**" The active expenditure of time and energy in regular employment. If the **employee** is on a paid vacation, or if it is a regular non-working day, or if the **employee** is on an approved leave of absence (except medical leave for the **employee's** own disabling condition), he will be considered actively at work so long as he was not disabled and was actively at work on the last preceding regular working day. An **employee** must not be **totally disabled** on the date coverage would otherwise take effect.

"**Beneficiary**" The person(s) whom the **insured** names to receive the death benefits. (For more details about the beneficiary, see the Beneficiary provision section of the **policy**.)

"**Contributory insurance**" Insurance for which the **policyholder** requires the **insured** to pay any part of the premium.

"**Employee**" An employee of the **employer** who is eligible for insurance under this **policy** as set forth in the Eligibility provision.

"**Employer**" The **policyholder** listed on the first page of this **policy**.

"**Enrollment"** The method used to enroll for insurance benefits under the group policy as designated by the **employer** and the **company**.

"**Home office**" The mailing address and telephone number of **our** home office are shown on the first page of this **policy**.

"**Insured**" Each insured **employee**. The insured has all ownership rights under this **policy**.

"**Noncontributory insurance**" Insurance for which the **policyholder** shall not require the **insured** to pay any part of the premium except where necessary to comply with applicable tax law.

"**Non-participating**" Annual dividends will not be paid under this **policy**.

"**Policy**" The policy issued to the **policyholder** shown on the first page.

"**Policy anniversary date**" The first day of each policy year after the first policy year.

"**Policyholder**" The policyholder listed on the first page of this **policy**.

"**Premium"** The amount the **policyholder**/**insured** will pay to **us** for the coverage provided under this **policy**.

"**Proof of loss" Written** evidence satisfactory to **us** that the conditions and requirements for any benefit described in the certificate have been satisfied.

"**Retirement date**" The date an **insured employee** retires from employment with the **policyholder**.

"**Salary**" The annual gross wage, salary or compensation, before any reductions, that an **insured employee** is receiving for performing the duties of his regular occupation for the **employer**. If considered part of his salary, this may include compensation for extracurricular duties, but does not include bonuses and overtime earnings.

"**Signed**" Any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

"**Total disability**", "**totally disabled**" As a result of injury or sickness, **you** are unable to perform the material duties of **your** regular job or any other job for which **you** are fit by education, training, or experience.

"**We**", "**Our**", "**Us**" "**Company**" Horace Mann Life Insurance Company.

"**Written**", "**writing**" A record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

"**Written request**" A request in **writing** in a form satisfactory to **us** and received at **our home office**.

Capitalization not normally capitalized according to the rules of standard punctuation, refers to a specific provision contained herein.

Eligibility

A person eligible for insurance under this **policy** is an **employee** of the **employer** who works full-time at least 17.5 hours per week for the **employer** and, if employed as a:

1) para-educator, has completed 45 days of employment;
2) maintenance **employee**, has completed 90 days of employment;
3) food-service **employee**, has completed 60 days of employment**.**

Such a person becomes eligible to apply for insurance for himself on:

1) the effective date of the **policy**, if eligible on or before such date; or
2) the date eligibility begins, if not eligible until after the effective date of the **policy**.

Proof of good health will not be required as long as the **employee** enrolls by completing and submitting an approved paper or electric form within 31 days after first becoming eligible, subject to any guaranteed issue limits outlined in the Schedule of benefits. Proof of good health will be required if the **employee** applies:

1) more than 31 days after initially becoming eligible for coverage;
2) for an amount in excess of the guaranteed issue amount; or
3) for an increase in coverage, except in the case of an approved open enrollment period.

If **enrollment** is not completed within 31 days, and coverage is:

1) **noncontributory insurance** – either all back premium must be paid based on the correct effective date or proof of good health satisfactory to the **company** will be required; or
2) **contributory insurance** – proof of good health satisfactory to the **company** will be required.

No insurance coverage will be provided for an **employee** if proof of good health of the **employee** is not satisfactory to the **company**. Any cost of providing proof of good health will be paid by **us**.

Effective date

Each **employee** who was eligible for insurance on or before the effective date of this **policy** will become insured on the effective date, as long as application is made on or before such date. If an **employee** was not eligible until after the effective date of this **policy**, he will become insured on the premium due date on or after the date his request for coverage is approved.

If an **employee** is not **actively at work** on the date he would otherwise become insured, coverage will not be effective until the premium due date on or after the day he returns to active work for one full day. However, this will not apply to any **employee** who was insured with the prior carrier on the day immediately before the effective date of this **policy**.

Death benefits

If an **insured** dies while he is covered by this **policy**, **we** will pay the death benefits. This benefit is the amount of insurance shown in the Schedule of benefits. Payment will be made in one lump sum to the **beneficiary**.

Instead of a lump sum payment, the **insured** can elect a settlement option. A settlement option allows the **insured** to choose how the death benefits will be paid. One option is the fixed number of monthly installments option. (See the table below.)

Table of fixed number of monthly installments

(NOTE: Term of years cannot result in monthly payments of less than $10.)

Number of years monthly installments will be paid	*Amount of monthly installment per $1,000 of death benefits
3	$28.99
4	22.06
5	17.91
10	9.61

(*These amounts will be calculated based on interest rates of 3% per annum.)

We can change this table to a new one. The new one will be similar to this one, but it will be based on a different interest rate. This change can occur when the **policy** is renewed or when the terms of the **policy** change. If this happens, the new table will not apply to any death that occurred before **we** changed to the new table.

If this or any other settlement option is desired, it may be provided; but **we** must first give **our** consent. The **insured** must write and tell **us** that he wants to elect a settlement option. He must also tell **us** the amount (what part or all) of the death benefits he wants the option to apply to.

When **we** receive **proof of loss**, payment will be made immediately. **Written proof of loss** must be given within 90 days from date of death, or as soon as possible. Proof must be furnished within 12 months from date of death, except in the absence of legal capacity. This payment will be based on a lump sum or whatever settlement option was elected and approved.

If the **insured** dies without having selected a mode of settlement, the **beneficiary** can elect a mode. He is subject to the same rules that apply above.

Premium

The first premium is due as of the effective date shown on the first page of this policy. The rest of the premiums are due according to the mode of payment selected by the **policyholder** as long as the **policy** is continued.

The maximum amount that a **policyholder** can require the **insured** to contribute to the cost of **contributory insurance** cannot exceed the premium charged for such insurance.

Premium computation and adjustment

Premium is computed on the basis of the Schedule of rates provision (below). These rates may be adjusted by any discounts or loading applicable to this **policy**.

A specific premium is charged based on each individual **insured**. This premium is based on the **insured's** age and the amount of insurance. The initial premium due for this **policy** is based on all those who were insured on the effective date of this **policy**. Premium is recalculated based on attained age each time the **policy** is renewed. Premium for any **insured** who becomes insured after the effective date of this **policy** is computed from his effective date. Premium is adjusted on the first premium due date on or after the date that any **insured** becomes eligible for a change in the amount of insurance.

If the **policyholder**/**insured** does not pay enough premium according to **our** calculations, **we** will let the **policyholder**/**insured** know. Then, the added amount will be due. If the **policyholder**/**insured** pays too much, **we** will let the **policyholder**/**insured** know. When **we** tell the **policyholder**/**insured** this, **we** will return the excess amount.

Change in rates

Rates may not change until 12 months after the effective date of this **policy**. Then, they may change on any premium due date. If the rates do change, **we** will give the **policyholder written** notice. This notice will be sent at least 31 days before the premium due date. **We** also have the right to change premium rates for changes that materially affect the risk assumed for the insurance provided under the policy, such as:

1) when the policy is changed by a rider, endorsement or amendment;
2) when a class of eligible persons is added to or deleted from the policy for any reason;
3) there is significant change in the geographic distribution of **insureds**; or
4) when a premium due date coincides with or next follows:
    a) a change in the number of covered persons greater than 15% since the later of the policy effective date and the last **policy anniversary date**; or
    b) a change in the amount of insurance provided under the policy greater than 15% since the later of the policy effective date and the last **policy anniversary date**.

Rates may also change on any other date agreed to by the **company** and the **policyholder**. Rates will not be changed more than once in any one 12 month period unless a plan change is requested by the **policyholder**.

Schedule of rates

We will compute the premium rates at the start of each **policy** year. The ages used will be the attained age of the individual **insureds**. The table of rates may change at the start of any **policy** term. In the event rates are based on age bracketing, attained age as of the effective date of this **policy** will be used to compute the monthly premium for the first **policy** term. Thereafter, attained age as of the **policy anniversary date** will be used to compute the monthly premium for the next **policy** term.

A change in premium rates will apply only to premiums due on or after the date the rate change takes effect.

Payment of premiums

All premiums are payable to **us** on or before the date they are due. **We** will give the **policyholder** a statement of premium due. Premiums are payable in advance of the due date by a mode of payment that has been mutually agreed upon between the **policyholder**/**insured** and **us**. Premium payments should be remitted to the address shown on the billing statement.

Grace period

The **policyholder**/**insured** has a grace period of 31 days after the premium due date to pay every premium due after the first. During this period, the coverage stays in force.

The only time this grace period does not apply is:

1) if the **policyholder** writes and tells **us** that this **policy** is to be discontinued; or
2) if an **insured** writes and tells **us** that his coverage under this **policy** is to be discontinued; or

3) if the **policyholder** writes and tells **us** that coverage for an **insured** is to be discontinued under this **policy**; or
4) if **we** decline to renew this **policy**. (For renewal information, see the first page.)

If the premium due is not paid by the due date, **we** will give **written** notification to the **policyholder/insured** that if the premium is not paid by the end of the grace period, this **policy** will end on the last day of the grace period. If **we** fail to provide such **written** notice, the insurance provided under this **policy** will continue in effect until the date such notice is given.

If the premium due is not paid during the grace period, and premium is being paid by the **policyholder**, this **policy** will terminate. If the premium is being paid by an **insured**, and the premium due is not paid during the grace period, coverage for the **insured** will terminate. The **policyholder/insured** must still pay all unpaid premium. This includes the premium due for the grace period. Any premium accepted after the date this **policy** terminates will not automatically reinstate this **policy**. Any unearned premium will be refunded by **us**.

The **policyholder/insured** must notify **us** in **writing** before the end of the grace period if the coverage is to be discontinued. Discontinuation will then be effective on:
1) the date requested by the **policyholder**; or
2) the first premium due date after **we** receive the **insured's written request**.

The **policyholder/insured** is still liable to **us** for the payment of any unpaid premium as well as the pro rata portion of the premium for any time during the grace period that the coverage continued in force.

Termination

Termination of insurance

The **insured's** insurance under the **policy** will end on the earliest date shown below:
1) the date the **policy** terminates;
2) the date the **policy** terminates a class of persons of which the **insured** is a member;
3) the date of expiration of the last period for which premium payment has been made to **us**;
4) the premium due date on or after the date the **insured** ceases to be a member of a class which is eligible for this insurance;
5) the premium due date on or after the date **we** receive a **written request** that the **insured's** coverage under the **policy** is to be discontinued;
6) the premium due date on or after the date the **insured** ceases active employment with the **employer**, except as outlined in the Continuation of insurance and Waiver of premium provisions.

The **insured** may elect the Conversion privilege at the time of termination of eligibility, subject to further provisions of that section.

Termination of the policy

If the **policyholder** replaces this **policy** with another group policy without giving **us written** notice of intent to end this **policy**, this **policy** will automatically terminate at the end of the grace period.

We may terminate this **policy** if:
1) there is less than 30% participation of those eligible persons for a contributory plan;
2) there is less than 100% participation of those eligible persons for a noncontributory plan;
3) the **policyholder** fails to provide information on a timely basis or fails to perform any obligations required by this **policy** or applicable law;
4) there are fewer than 10 **insureds** under the **policy**; or
5) the **policyholder** fails to pay any premium within the grace period.

If **we** decline to renew this **policy**, **we** will send **written** notice to the **policyholder**. Notice will be sent at least 31 days before time to renew. It will be sent to the address of the **policyholder** as shown in **our** records.

If this **policy** is terminated, the **policyholder** will provide **written** notice to all **insureds** of their rights as provided in the certificate (including conversion privileges). This notice must be provided to each **insured** as soon as reasonably possible.

General provisions

Conformity with standards

This policy was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the policy that on the provision's effective date is in conflict with standards of the Interstate Insurance Product Regulation Commission (or any successor organization) for this product type is hereby amended to conform to such standards for this product type as of the provision's effective date.

Insureds' individual certificates

We will supply the certificate to the **policyholder** for delivery to each **insured**. The certificate will describe the insurance **we** provide; and it will state the **insured's** conversion rights.

Misstatement of age

If the age of any **insured** is incorrectly stated, the coverage amount will be the amount of insurance, based on the Schedule of benefits at the **insured's** correct age. The premium will be adjusted so that the amount payable will be the amount due based on the **insured's** correct age.

Policy changes

The **policy** and certificate may be changed, at any time, without the consent of the **insured** or anyone else with a beneficial interest in it. Any such change must be shown in **writing**. **We** may issue riders, endorsements or amendments to effect such changes, as long as these forms have been approved by the Interstate Insurance Product Regulation Commission. Such changes must be consistent with the Interstate Insurance Product Regulation Commission standards and will not affect the insurance provided under the certificates until the effective date of the change, unless retroactivity is required by the Interstate Insurance Product Regulation Commission. Any change or waiver of the terms and provisions of the **policy** and certificate will be evidenced by a rider, endorsement or amendment **signed** by an officer of the **company**.

A sales representative, or other employee of the **company**, who is not an officer of the **company** does not have the **company's** authority to approve such changes or waivers.

A copy of the rider, endorsement or amendment will be provided to the **policyholder** for attachment to the **policy**, and will also be provided to the **insured** for attachment to the certificate if the change affects the certificate. Any rider, endorsement or amendment added to the **policy** after the date of issue that diminishes rights, benefits or coverage in the **policy** will require **signed** acceptance by the **policyholder**.

Policy entire contract

The entire contract between the parties consists of:

1) this **policy** and the certificate including any amendments, riders, or endorsements attached to this **policy** and to the certificate; and
2) the application of the **policyholder** (a copy is attached).

Policy incontestability

This **policy** cannot be contested after two years from its effective date, except for nonpayment of premium. Anything the **policyholder** states in the application cannot be used against the **policyholder** with respect to this insurance after two years from the effective date of insurance. Changes in the amount of insurance will not be contested after two years from the date the change goes into effect. The statement on which the contest is based must be material to the risk accepted or the hazard assumed by **us**.

All statements made by the **policyholder** or by the **insured** will, in the absence of fraud (when permitted by applicable laws in the state where this **policy** is delivered or issued for delivery), be deemed representations and not warranties. No statement can be used to avoid insurance, reduce benefits or defend a claim unless it is included in a **written** application which has been made a part of this **policy**.

Registry of individuals insured

The **policyholder** must give **us** the names of all individuals initially insured. The **policyholder** must also give **us** names of persons who later become eligible (whether or not they become insured), and the **policyholder** must tell **us** who ceases to be eligible. The eligibility dates and any other necessary data should be given to **us** so that the premium can be determined.

We have the right to check the **policyholder's** books and records as they relate to this insurance. **We** can authorize someone else to check for **us**. Any such inspection can be done at any reasonable time.

Any clerical error in keeping the records will not keep insurance in force if it should have been terminated; nor will it terminate insurance that should have been kept in force. As soon as the error is found, the proper premium adjustment will be made. If too much premium has been paid to **us**, **we** will make a refund of any overpayment. If too little premium has been paid, the **policyholder** must pay the additional premium or coverage will terminate as outlined in the "Termination" provision. Premium adjustments will be limited to the twelve month period immediately preceding the date **we** receive notice in the **home office** that such an adjustment needs to be made.

Incorporation provision

Certificate

The Group Term Life Insurance Certificate, including the Schedule of benefits and any riders, endorsements or amendments listed below are attached to this **policy** and are hereby incorporated into, and made a part of, this **policy**:

Certificate	Riders, Endorsements or Amendments
ICC18-LCG000	ICC18-L6C27X and any endorsements, riders, or amendments issued after the effective date of this policy.

The terms found in the certificate will control:

1) the benefit plan provisions;
2) the termination of insurance rules;
3) exclusions; and
4) other General provisions pertaining to state insurance law requirements.

Horace Mann Life Insurance Company
1 Horace Mann Plaza
Springfield, Illinois 62715-0001
1-800-999-1030
horacemann.com

Policyholder: Burlington School District

Policy effective date: January 1, 2020

Group number: 440111 {Optional Life}

Group Term Life Insurance Certificate

One Year Renewable Term Insurance – **Contributory insurance**
Non-participating – With a Conversion Option

We have issued a **policy** of group term life insurance to the above named **policyholder**. The **policy** is a contract between the **company** and the **policyholder** and may be changed or ended without **your** consent. **Our** name, the **policyholder's** name and the group number are shown above. The group **policy** insures certain **employees** of the **policyholder**. **We** certify that **you** are insured for benefits described in this certificate, subject to the provisions of this certificate. This certificate is not the entire contract of insurance. It is a part of the **policy** and is evidence of **your** life insurance coverage under the policy. **Your** benefits and rights under the **policy** will not be less than those stated in this certificate. This certificate replaces the original certificate (Group number 440111) issued 1/1/1992 and any subsequent version **we** may have given to **you**.

Read your certificate carefully —Insurance benefits may be subject to certain requirements, reductions, limitations and exclusions of the policy.

Notice of Your Right to Examine this Certificate

It is important for you to be satisfied with this certificate. We hope that it meets your insurance goals. If you are not satisfied, you may return the certificate to us within 30 days after it is delivered to you, or any longer period as may be required if this certificate was purchased as a replacement of other coverage as defined by the state where the certificate is delivered. You may return the certificate to us or to the agent from whom you purchased it. Once we receive the certificate, we will refund any premiums you have paid. Return of the certificate will void it as if it had never been issued.

Vermont Department of Insurance
Telephone Number: 802-828-3301

Alphabetical table of contents

Schedule of benefits

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19) Department 18 with Optional Life	$25,000
22) Department 21 with Optional Life	$37,500

Changes in amount of insurance

Any change in **your** amount of insurance will become effective on the premium due date on or after the date **you** become eligible for the change.

If applicable, amounts may change as shown in the Schedule of benefits when **you** move from one classification to another.

You must be **actively at work** on the date of the change except as outlined in the Waiver of premium provision. If not, the change will not become effective until the premium due date on or after the date **you** return to active work.

Definitions

The terms **we** use in this certificate are defined below. When these terms appear elsewhere in this certificate, they will be in **bold** print. Any pronouns used in this certificate will apply to the appropriate gender.

"**Actively at work**" The active expenditure of time and energy performing all of the usual and customary duties of **your** job. If **you** were on a paid vacation, or if it is a regular non-working day, or if **you** are on an approved leave of absence (except medical leave for **your** own disabling condition and lay-off), **you** will be considered actively at work so long as **you** were not disabled and were actively at work on the last preceding regular working day. **You** must not be **totally disabled** on the date coverage would otherwise take effect.

"**Beneficiary**" The person(s) whom **you** name to receive the death benefit. (For more details about the beneficiary, see the Beneficiary provision of this certificate.)

"**Contributory insurance**" Insurance for which the **policyholder** requires **you** to pay any part of the premium.

"**Employee**" An employee of the **employer** who is eligible for insurance under the **policy** as set forth in the Eligibility provision.

"**Employer**" The **policyholder** listed on the first page of this certificate.

"**Enrollment"** The method used to enroll for insurance benefits under the group policy as designated by the **employer** and the **company**.

"**Home office**" The mailing address and telephone number of **our** home office are shown on the first page of this certificate.

"**Insured**" Each insured **employee**. The insured has all ownership rights under this certificate.

"**Noncontributory insurance**" Insurance for which the **policyholder** does not require **you** to pay any part of the premium, except where necessary for the **policyholder** to comply with applicable tax law.

"**Non-participating**" Annual dividends will not be paid under the **policy**.

"**Policy**" The policy issued to the **policyholder** shown on the first page of this certificate.

"**Policyholder**" The policyholder listed on the first page of this certificate.

"**Proof of loss" Written** evidence satisfactory to **us** that the conditions and requirements for any benefit described in this certificate have been satisfied.

"**Retirement date**" The date **you** retire from employment with the **policyholder**.

"**Salary**" The annual gross wage, salary or compensation, before any reductions, that **you** are receiving for performing the duties of **your** regular occupation for the **employer**. If considered part of **your** salary, this may include compensation for extracurricular duties, but does not include bonuses and overtime earnings.

"**Signed**" Any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

"**Total disability**", "**totally disabled**" As a result of injury or sickness, **you** are unable to perform the material duties of **your** regular job or any other job for which **you** are fit by education, training, or experience.

"**We**", "**Our**", "**Us**", "**Company**" Horace Mann Life Insurance Company.

"**Written**", "**writing**" A record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

"**Written request**" A request in **writing** in a form satisfactory to **us** and received at **our home office**.

"**You**" "**Your**" Each **insured employee** of the **employer**.

Capitalization not normally capitalized according to the rules of standard punctuation, refers to a specific provision contained herein.

Eligibility

You are eligible for insurance under the **policy** if **you** are an employee of the **employer** who works at least 17.5 hours per week for the **employer** and, if employed as a:

1) para-educator, have completed 45 days of employment;
2) maintenance **employee**, have completed 90 days of employment;
3) food-service **employee**, have completed 60 days of employment**.**

You become eligible to apply for insurance for yourself on:

1) the effective date of the **policy**, if eligible on or before such date; or
2) the date eligibility begins, if not eligible until after the effective date of the **policy**.

Proof of good health will not be required as long as **you** enroll by completing and submitting an approved paper or electronic form within 31 days after **you** become eligible, subject to any guaranteed issue limits outlined in the Schedule of benefits. Proof of good health will be required if **you** apply:

1) more than 31 days after **you** initially become eligible for coverage;
2) for an amount in excess of the guaranteed issue amount; or
3) for an increase in coverage, except in the case of an approved open enrollment period.

If **enrollment** is not completed within 31 days, and coverage is:

1) **noncontributory insurance** – either all back premium must be paid based on the correct effective date or proof of good health satisfactory to the **company** will be required; or
2) **contributory insurance** – proof of good health satisfactory to the **company** will be required.

No insurance coverage will be provided to **you** if proof of **your** good health is not satisfactory to the **company**. Any cost of providing proof of good health will be paid by **us**.

Effective date

If **you** were eligible for insurance on or before the effective date of the **policy**, **you** will become insured on that effective date, as long as **you** enroll on or before such date. If **you** were not eligible until after the effective date of the **policy**, **you** will become insured on the premium due date on or after the date **your** request for coverage is approved.

If **you** are an **employee** and not **actively at work** on the date **you** would otherwise become insured, coverage will not be effective until the premium due date on or after the day **you** return to active work for one full day. However, this will not apply if **you** were insured with the prior carrier on the day immediately before the effective date of the **policy**.

Life insurance benefits

If **you** die while covered by this certificate, **we** will pay the death benefit upon receiving **proof of loss**. This benefit is the amount of insurance shown in the Schedule of benefits. Payment will be made to the **beneficiary** in either one lump sum payment or under a settlement option.

Filing a claim

Written proof of loss must be sent to **us** within 90 days from date of death, or as soon as reasonably possible.

Acceptable **proof of loss** consists of a certified copy of the death certificate, or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds. **We** will review the **proof of loss** and if approved, **we** will pay benefits subject to the terms of this certificate.

The time limit on legal actions for loss covered by this certificate is subject to applicable law in the state where the **policy** is issued. This payment will be based on a lump sum or whatever settlement option was elected and approved.

Your beneficiary may contact **our home office** to obtain a claim form. The process for submitting a claim will be explained in the claim form kit. If the claim form kit is not received within 15 days of the **beneficiary's** request, **your beneficiary** may send **us proof of loss** on any form sufficient to provide **us** with acceptable **proof of loss**.

We will pay interest on the death benefit from the date of death to the date the death benefit is paid. Interest will be paid at the same rate as funds left on deposit with the **company**. In determining the effective annual rate or rates, **we** will use the rate in effect on the date of death.

Additional interest at a rate of 10% annually will accrue beginning 31 calendar days from the latest of the following items to the date the claim is paid:

- the date that due **proof of loss** of the **insured** is received by the **company**;
- the date the **company** receives sufficient information to determine its liability, the extent of the liability, and the appropriate **beneficiary** legally entitled to the death benefit; and
- the date that legal impediments to payment of death benefit that depend on the action of parties other than the **company** are resolved and sufficient evidence of the same is provided to the **company**. Legal impediments to payment include, but are not limited to: (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; and (c) the submission of information required to satisfy state and federal reporting requirements.

Beneficiary provision

The **beneficiary** named in the application or during the **enrollment** process, unless later changed by **written request**, is entitled to the death benefit of this certificate unless prohibited by state law. **You** can name a new **beneficiary** at any time. **You** do not need the consent of the existing **beneficiary** to do this except in community property states or where the **beneficiary** has been named irrevocable. (If the **beneficiary** has been named irrevocable, see below.) If **you** enter into an absolute assignment, **you** give up all of the rights **you** would normally have to name a **beneficiary** without the assignee's consent.

You must give **us** a **written request** for the change. Then, the change will not be effective until the request is received at **our home office**. When received, the change takes effect as of the date that the **written request** was **signed**. This will happen even if **you** die between the time **you** make the request and the request is received. However, if any amount is paid before **your** request for a change is received, it will not be subject to the request for change.

You can make an irrevocable **beneficiary** designation. This means that **you** give up **your** right to change the **beneficiary** without the consent of the irrevocable **beneficiary**. The only way **you** can get this right back is if:

1) the **beneficiary** gives his **written** consent; or
2) the **beneficiary** dies.

If an irrevocable **beneficiary** designation or an absolute assignment is in effect, the rules about **you** changing the **beneficiary** stated above do not apply.

If more than one **beneficiary** is named, benefits will be paid equally to each **beneficiary**, unless otherwise designated

by **you**. If the **beneficiary** dies before **you** die, the death benefit will be payable to **your** estate; or, at **our** option, **we** can make payment to the first surviving class of successive preference beneficiaries: **your** (a) widow or widower; (b) surviving children; (c) surviving parents; (d) surviving brothers and sisters; (e) executors or administrators. Payment will be made in one lump sum. This same rule will apply if **you** did not name a **beneficiary**.

If any **beneficiary** dies within fifteen days of the date **you** die, the amount that would have been paid to the **beneficiary** will be treated as though that **beneficiary** had died before **you**. This does not apply to any payment that is made to such **beneficiary** during the fifteen days following **your** death. **You** can arrange (when **you** name the **beneficiary**) for the portion of the death benefit that is payable to any deceased **beneficiary** to be treated in some other manner.

If **you** apply for a conversion policy and **you** name a new **beneficiary** on that application, **we** will consider this to be a request for a change of **beneficiary** under this certificate. This means that if **you** have applied for a conversion policy but that policy has not yet taken effect, the change in **beneficiary** will apply even though the conversion policy itself does not. For more details about conversions, see the Conversion privilege section of this certificate.

The death benefit will be paid to the **beneficiary** if he can give **us** a valid release for that payment. He cannot give a valid release if he is a minor or if the law deems him unable to do so. If he cannot give a release, payment can go to someone else. **We** can pay the benefit to anyone whom **we** feel is entitled to the benefits; however, he must show **us** that he has assumed the care and main support of the **beneficiary** who was supposed to receive the benefit.

Any payment **we** make is done so in good faith; it will fully discharge **us** for the amount of such payment. **You** may contact **our home office** for a **beneficiary** change form.

Termination of insurance

Your insurance under the **policy** will end on the earliest date shown below:

1) the date the **policy** terminates;
2) the date the **policy** terminates a class of persons of which **you** are a member;
3) the date of expiration of the last period for which premium payment has been made to **us**;
4) the premium due date on or after the date **you** cease to be a member of a class which is eligible for this insurance;
5) the premium due date on or after the date **we** receive a **written request** that **your** coverage under this certificate is to be discontinued;
6) the premium due date on or after the date **you** cease active employment with the **employer**, except as outlined in the Continuation of insurance and Waiver of premium provisions.

You may elect the Conversion privilege at the time of termination of eligibility, subject to further provisions of that section.

Continuation of insurance

If **your** insurance would end solely because **you** are not **actively at work**, coverage may be continued during the instances outlined below, as long as **your** leave has been approved by the **employer** and the **employer** continues to remit the required premium on the same basis as premium was paid on the day before **you** ceased active employment:

1) leave of absence, including sabbatical, for up to one year;
2) vacation time for up to 3 months;
3) temporary military leave for up to 6 months. However, if death occurs while on active duty in the military as a result of such military service, including war or act of war, whether declared or undeclared, benefits will not be payable;
4) temporary lay-off for up to 3 months;
5) family and medical leave for up to the earlier of the end of the approved leave of absence or the leave period required by the Federal Family Leave Act of 1993 and any amendments (The **policyholder** has established a policy for family and medical leave in compliance with the FMLA. The **employee** should contact the **policyholder** to

determine eligibility and the terms, conditions and cost for continuation of insurance during a leave.);

6) absence due to **total disability**, until the earlier of:
   a) the date **you** are no longer **totally disabled**, as defined in this certificate;
   b) 9 months from the date **your total disability** began;
   c) the date **you** are approved for the Waiver of premium benefit; or
   d) the date of **your** 65th birthday.

Unless continuation of insurance is due to **total disability**, it will end if any of the following events should occur:

1) **you** return to work;
2) the **policy** terminates;
3) the **policy** terminates a class of persons of which **you** are a member;
4) **you** cease to be a member of a class which is eligible for this insurance;
5) **we** do not receive the required premium; or
6) **your employment** terminates.

Any leave of absence will run concurrently with any other Continuation of insurance provision of the policy. If **you** die during the continuation period, **we** will pay the death benefit to **your** beneficiary upon receipt of **proof of loss** establishing that **you** died during the continuation period.

If **you** are no longer eligible for insurance under the policy at the end of the continuation period, **you** may convert **your** coverage as outlined in the Conversion privilege provision below.

Should **you**/**your employer** choose not to continue paying the required premium, **you** will cease to be eligible for insurance under the policy. **Your** coverage may be reinstated upon **your** return to active employment in an eligible class.

Waiver of premium

If **you** become **totally disabled**, **we** will waive premium payment after the first nine months of **total disability**. Premium payments must continue to be remitted by the **policyholder** during this nine-month period. **You** must become disabled while **you** are insured under this certificate and prior to the attainment of age 60.

You must give **us** satisfactory **written** proof of **your total disability**. Proof should be given when **total disability** has been continuous for at least nine months. Such proof must be given within 12 months after the date **total disability** begins. A delay will not cause the claim to be denied or reduced if such proof is given as soon as reasonably possible. **We** will not ask **you** to send initial **written** proof of disability to **us**. **You** must automatically do it on **your** own; or **you** can have someone do it for **you**. **We** can, however, ask for additional proof of the existence and continuance of the **total disability**. **We** can ask for this proof as often and whenever **we** feel it is necessary until **your** waiver of premium has been approved. After that, **we** cannot ask for proof more than once a year. **We** can also have **you** examined by a doctor of **our** choice, at **our** expense. In the case of conflicting opinions, eligibility for waiver benefits will be determined by a third medical opinion, paid for by **us**, provided by a physician that is mutually acceptable to both **you** and **us**. Continued proof must be in **writing** and must be received within three months of **our** request.

After **our** initial review of **your** claim, **we** will notify **you** in **writing** to let **you** know if **you** have been approved for the Waiver of premium benefit. If approved, **we** will include the amount of premium that will be waived. The amount of insurance that will be continued will be the amount in force on the date **you** became **totally disabled**. This amount will be reduced or terminated based on the Schedule of benefits in effect on the date **total disability** begins. This amount will not be increased while **you** remain **totally disabled**. The amount of insurance will not be reduced by the premiums waived under this provision. If insurance is being continued under this section of this certificate, it will be in lieu of all other life insurance benefits provided by this certificate.

If **you** die while covered under this section, **written** proof of loss must be given to **us**. If this proof is not given, **we** will not be liable for any payment.

Written proof that **total disability** continued without interruption until the date of death must be given to **us**.

Insurance will not be continued under this section if the **total disability** is the result of:
1) any intentionally self-inflicted injury or sickness;
2) war or an act of war, whether declared or not;
3) riot, insurrection, or participation in such;
4) air travel or any sort of air or flying operations or activities, except as a fare-paying passenger. If a person pays a fare, the aircraft must be operated by a concern licensed to carry passengers for hire,
5) being intoxicated or under the influence of any narcotic unless taken as prescribed on the advice of a physician; or
6) committing or attempting to commit a felony.

Waiver of premium will end on the earliest of:
1) the date of **your** death;
2) the date **your total disability** ends;
3) failure to provide proof of continued **total disability** as requested;
4) **your** refusal to be examined by a physician;
5) **your** attainment of age 65; or
6) **your retirement date**.

If **you** are again in a class eligible for insurance under the **policy**, premium will again be required. If **you** do not return to an eligible class for insurance, **your** insurance continues to the date that premium has been waived and then it stops. This applies if **you** fail to give **us** proof of continued **total disability**, too. In the event **your** insurance does stop, **you** may convert **your** coverage as outlined in the Conversion privilege provision below.

Conversion privilege

If **you** have assigned all of **your** ownership rights absolutely to an assignee, then, the assignee (instead of **you**) is entitled to exercise the Conversion privilege.

You may convert **your** group life insurance to an individual permanent life insurance policy if:
1) **You** are no longer in an eligible class;
2) **You** end active employment with the **employer**;
3) **Your** coverage under the Continuation of insurance provision ends;
4) **Your** portability coverage, if any, ends;
5) The group **policy** ends;
6) The **policy** is changed to end life insurance for the eligible class to which **you** belong.

You may also convert **your** group life insurance that ends due to a reduction of life insurance that is due to:
1) Attaining a specific age;
2) **You** changing from one eligible class to another; or
3) A policy change.

We must receive **your** completed application and the first full premium for the new policy in **our home office** within 31 days of the date of termination or reduction.

No evidence of insurability will be required. The converted policy will not have a waiver of premium benefit or any other supplementary benefits. The converted policy will be an individual permanent life insurance policy customarily offered by **us**. There will always be available at least one permanent policy to which a conversion will be permitted. The amount cannot be more than the amount of life insurance which ceases, minus any new group coverage for which **you** become eligible within 31 days.

If insurance stops because the **policy** terminates or because the **policy** is changed so that a class of **insureds** of which **you** are a member is terminated, **you** can convert; however, **you** must have been insured for at least five years under the **policy**. Conversion is subject to the same rules outlined above, except the amount will not exceed the smaller of:
1) the amount of insurance ceasing, less the amount **you** are or become eligible for under any group policy issued within 31 days of the date this insurance stops; and

2) two thousand dollars.

If **you** die during the time **you** had a right to apply for a conversion policy but before such policy becomes effective, an amount of life insurance will be payable. The amount will be that which **you** would have been entitled to have issued to **you** under the conversion policy. The amount will be payable as a claim under this certificate; and any premium payment on the conversion policy will be refunded.

This Conversion privilege is in lieu of all other benefits under this certificate. The effective date of the conversion policy will be the thirty-second day after the date that premiums were paid to under this certificate.

You will be given notice by the **policyholder** of **your** conversion right at least fifteen days prior to the date insurance ends or is reduced. If **you** are not given this notice at least sixteen days before the end of the conversion privilege period, **you** have an additional period of time to exercise **your** right. This period ends fifteen days after the date **you** are given notice; and it will not go past sixty days after the original thirty-one day period.

Notice will be mailed by the **policyholder** to **your** last known address. In no event, however, will **your** insurance under this certificate be continued beyond the original thirty-one day period.

No death benefit will be paid under this certificate if an individual life insurance policy has been issued as a conversion from the **policy** unless the individual policy is surrendered to **us**. No claim under that individual policy can be made other than a refund of all premiums paid for it less any payments made by **us**, and less any unpaid policy loans (if applicable).

1) The premium for the individual policy will be based on the premium rates currently in use by **us**;
2) The form and amount of insurance being converted;
3) **Your** premium risk class;
4) **Your** attained age when insurance under the **policy** ends or is reduced.

Grace period

The **policyholder** has/**You** have a grace period of 31 days after the premium due date to pay every premium due after the first. During this period, coverage stays in force.

The only time this grace period does not apply is:

1) if the **policyholder** writes and tells **us** in advance that the **policy** is to be discontinued in accordance with the terms of the **policy**; or
2) if **you** write and tells **us** in advance that **your** coverage under this certificate is to be discontinued; or
3) if the **policyholder** writes and tells **us** in advance that **you** are no longer eligible for coverage under the **policy**; or
4) if **we** decline to renew the **policy**.

If the premium due is not paid during the grace period, and premium is being paid by the **policyholder**, the **policy** will terminate. If the premium is being paid by **you**, and the premium due is not paid during the grace period, **your** coverage will terminate. The **policyholder** is/**You** are still liable to **us** for the payment of any unpaid premium as well as the pro rata portion of the premium for any time during the grace period that the coverage continued in force.

You must notify **us** in **writing** before the end of the grace period if **your** coverage is to be discontinued. Discontinuation will then be effective on the first premium due date after **we** receive **your written request**.

General provisions

Assignment – claims of creditors

Any assignment, unless otherwise specified by **you**, will take effect on the date the notice of assignment is **signed** by **you** and the assignee, subject to any payments made or action taken by **us** prior to receipt of such notice at **our home office.** The assignment must be received in a **written request**. The **written** consent of any irrevocable beneficiary will be required as part of the **written request**. **We** will accept either the original or a copy. **We** do not take any responsibility for any assignment being valid or complete.

Benefits are exempt from legal process of **your** or **your beneficiary's** debts, to the extent provided by law.

You can make a collateral assignment or an absolute assignment. A collateral assignment reverts the ownership rights back to **you** at the time the conditions of the assignment are satisfied. If **you** enter into an absolute assignment, however, **you** give up all of the ownership rights **you** would normally have, including the right to name a **beneficiary** and the right to convert coverage without the assignee's consent.

Certificate entire contract

The entire contract with the **policyholder** consists of the **policy**, the **policyholder's** application, this certificate, plus any amendments, endorsement or riders attached to the **policy** and this certificate. Contact **your employer** to inspect a copy of the **policy**.

Certificate incontestability

Your coverage under this certificate cannot be contested after two years from its effective date, except for nonpayment of premium. Anything **you** state relating to **your** insurability cannot be used against **you** after two years from **your** effective date of insurance. The statement must be in **writing** and **signed** by **you**. Changes in the amount of insurance will not be contested after two years from the date the change goes into effect. The statement on which the contest is based must be material to the risk accepted or the hazard assumed by **us**.

All statements made by **you** will, in the absence of fraud (when permitted by applicable laws in the state where this certificate is delivered), be deemed representations and not warranties. No statement of insurability made by **you** can be used to avoid insurance, reduce benefits or defend a claim unless **signed** by **you** and a copy of that statement is or has been furnished to **you** or **your beneficiary**.

Conformity with standards

This certificate was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of the certificate that on the provision's effective date is in conflict with standards of the Interstate Insurance Product Regulation Commission (or any successor organization) for this product type is hereby amended to conform to such standards for this product type as of the provision's effective date.

Misstatement of age

If **your** age is incorrectly stated, the coverage amount will be the amount of insurance, based on the Schedule of benefits at **your** correct age. The premium will be adjusted so that the amount payable will be the amount due based on **your** correct age.

Policy changes

The **policy** and certificate may be changed, at any time, without **your** consent or anyone else with a beneficial interest in it. Any such change must be shown in **writing**. **We** may issue riders, endorsements or amendments to effect such changes, as long as these forms have been approved by the Interstate Insurance Product Regulation Commission. Such changes must be consistent with the Interstate Insurance Product Regulation Commission standards and will not affect the insurance provided under the certificates until the effective date of the change, unless retroactivity is required by the Interstate Insurance Product Regulation Commission. Any change or waiver of the terms and provisions of the **policy** and certificate will be evidenced by a rider, endorsement or amendment **signed** by an officer of the **company**.

A sales representative, or other employee of the **company**, who is not an officer of the **company** does not have the **company's** authority to approve such changes or waivers.

A copy of the rider, endorsement or amendment will be provided to the **policyholder** for attachment to the **policy**, and will also be provided to **you** for attachment to the certificate if the change affects the certificate. Any rider, endorsement or amendment added to the **policy** after the date of issue that diminishes rights, benefits or coverage in the **policy** will require **signed** acceptance by the **policyholder**.

Suicide

If **you** commit suicide, while sane or insane, within two years of **your** effective date of coverage under this certificate or any predecessor certificate, benefits will not be payable. **We** will refund the premiums that were paid for the coverage to:

1) the **beneficiary** if premium was paid by **you**; or.
2) the **policyholder** if premium was paid by the **policyholder**.

If **you** commit suicide, while sane or insane, within two years from the effective date of an increase in coverage, **we** will pay the **beneficiary** the amount of insurance that was in effect prior to the increase. Any premium paid by **you** for the increase will be paid by to the **beneficiary**. Any premium paid by the **policyholder** will be returned to the **policyholder**.

Rider

Horace Mann Life Insurance Company
1 Horace Mann Plaza
Springfield, Illinois 62715-0001
1-800-999-1030
horacemann.com

Accelerated Benefit Rider

Rider effective date: January 1, 2020 Group #: 440111 {Basic Life}

NOTE: The benefits paid under this rider are intended to be treated as accelerated death benefits that are governed by Section 101(g)(1) of the Internal Revenue Code of 1986, as amended. Benefits paid under this rider may be taxable and may also affect Medicaid, government benefits, or claims of creditors. Please consult with your tax or financial advisor before you apply for this benefit.

The death benefit will be reduced if an accelerated benefit is paid.

This rider is a part of the certificate to which it is attached. It provides coverage specifically for accelerated benefits. This rider is subject to all other provisions that control the **policy**, unless specifically stated otherwise. This rider will become effective on the same day as the certificate to which it is attached, unless otherwise stated above. In the event there is a conflict between any provisions in this rider and the policy/certificate to which this rider is attached, the provisions in this rider will apply.

Defined (bolded) terms used but not defined in this rider have the meaning given to them in the certificate to which this rider is attached. As used in this rider, the term "insured person" refers to **you.**

This rider is not available for insured retirees.

Definitions

"**Physician**" means a licensed medical doctor (M.D.) or a licensed doctor of osteopathy (D.O.) as defined in section 1861(r)(1) of the Social Security Act practicing within the scope of his or her license. Physician does not include **you**, the insured person or a member of the insured person's or **your** immediate family.

"**Physician's statement"** means a written statement acceptable to **us**, signed by a **physician**, which certifies and gives the **physician's** diagnosis of the insured person's **terminal illness**.

"**Terminal illness**" means an illness or physical condition of the insured person that, notwithstanding appropriate medical care, can reasonably be expected to result in death in 12 months or less from the date of the **physician's statement**.

Benefits

If an insured person is diagnosed with a **terminal illness**, **you** may request payment of the accelerated benefit. Both the diagnosis and the payment request must be made while covered under this rider. In order to apply, **you** must give us:
1) a **physician's statement**; and
2) a completed claim form.

We reserve the right to require a second opinion by having an insured person examined by a **physician** of **our** choice at **our** expense. In the case of conflicting opinions, eligibility will be determined at **our** expense by a third opinion that is provided by a **physician** who is mutually acceptable to **you** and **us**.

The minimum amount that may be requested is $5,000. The amount of the accelerated benefit available under the certificate is limited to 50% of the death benefit for which such person is insured under the certificate or $50,000, whichever is less. However, if the death benefit for the insured person is scheduled to reduce within 12 months of the date **you** apply for the accelerated benefit, the benefit payable under this rider will be based on the reduced amount.

The cost of the benefit is assessed as a discount to the accelerated benefit when it is paid. The benefit is discounted using simple interest and the expected lifetime of the insured person. The discount rate will not exceed the greater of the following:

a) the current yield on a 90-day treasury bill on the date of the application for an accelerated payment; or
b) the current Moody's Corporate Bond Yield Averages - the Monthly Average Corporates published by Moody's Investor Services, Inc., or successor thereto, for the calendar month ending two months before the date of application for an accelerated payment. If the averages are no longer published, we will use other averages as permitted by the Interstate Insurance Product Regulation Committee.

Upon request of payment of an accelerated benefit and again upon payment of the benefit, **we** will provide a statement which will disclose the discount rate and expenses associated with the benefit payment, the remaining death benefit and the effect on premium for the remaining coverage. The death benefit immediately prior to the payment of the accelerated benefit amount will be reduced on a pro rata basis. Future benefit amounts will be calculated according to the methods described in the certificate minus the amount that was accelerated. The premium will remain unchanged.

If **you** elect to accelerate a portion of **your** death benefit, it will not impact benefits for any of **your** covered dependents, if applicable, whether or not the dependent coverage is based on a percentage of **your** death benefit. If an insured person dies after **you** elect to receive an acceleration of that insured person's death benefit, but before any such benefit is received, the election will be cancelled and the death benefit will be paid pursuant to the certificate.

We will pay the accelerated benefit to **you** in a lump sum as soon as **proof of loss** is received.

Limitations

The accelerated benefit cannot be paid if:

1) **you** have assigned all or a portion of the death benefit or named an irrevocable **beneficiary**, unless we receive written consent from the assignee or irrevocable **beneficiary**;
2) **you** are required by court order to pay all or part of the group life insurance benefit under the certificate to another person;
3) **you** would be required by law to use the proceeds of the death benefit to meet the claims of creditors, whether or not in bankruptcy;
4) **you** are required by a government agency to use the payment to apply for, receive or maintain governmental benefit or entitlement;
5) **you** are married and live in a community property state, unless **your** spouse gives written consent; or
6) **You** have previously received an accelerated benefit for the insured person under this policy or any other group policy held by the **policyholder**.

Termination of Accelerated Benefit

An insured person's coverage under this rider will terminate on the earliest of:

1) the date the insured person's life insurance coverage under the certificate terminates;
2) the date this rider terminates;
3) the date the certificate terminates; or
4) the date the **policy** terminates.

If an insured person's coverage under this rider ends, this will not prejudice the payment of benefits for any qualifying event that occurred while this coverage was in force.

Termination of Accelerated Benefit Rider

We may terminate this accelerated benefit rider by giving the group **policyholder** at least 31 days prior written notice.

Corporate Secretary

President

Horace Mann Life Insurance Company
Home Office: 1 Horace Mann Plaza
Springfield, Illinois 62715-0001
1-800-999-1030

Vermont Life Insurance
Mandatory Civil Union Endorsement

Purpose —
This endorsement is part of the policy, contract, certificate and/or riders and endorsements to which it is attached and is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

General definition, terms, conditions and provisions —
The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.

Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.

"Dependent" means a spouse, a part to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

"Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

CAUTIONARY DISCLOSURE —
THIS ENDORSEMENT IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE ENDORSEMENT. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS ENDORSEMENT. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

Horace Mann®
Insuring America's Educational Community

Underwritten by
Horace Mann Life Insurance Company
1 Horace Mann Plaza
Springfield, Illinois 62715-0001
217-789-2500

APPLICATION FOR GROUP INSURANCE

Association or Employer Burlington School District
(Herein Called the Group Policyholder)

Nature of Business of Group Policyholder

Address 150 Colchester Ave. (Street and Number) Burlington (City) VT (State) 05401 (Zip Code)

TYPE OF COVERAGE

LIFE Life/AD&D - Benefit Classed @ $.22/1,000 Life $.03/1,000 AD&D.
Optional Life - Benefit Classed Age Rated.

MEDICAL

DISABILITY

INDEMNITY

OTHER

REQUESTED EFFECTIVE DATE 01/01/92

ELIGIBILITY

Total Number of Persons Affiliated with the Proposed Policyholder

Total Number of Persons Eligible 491

Persons Eligible

All Persons in the following classes are eligible for insurance under the policy.

TYPE OF COVERAGE	CLASS	DEFINITION	COVERAGE AMOUNT

Persons in the following classes or locations are NOT Eligible

DATE OF ELIGIBILITY

On the effective date of the Policy, persons of an eligible class as defined above shall become eligible for insurance:

___ on the effective date.

___ on _____

Persons entering an eligible class as defined above after effective date shall become eligible for insurance:

___ on first day of employment.

___ on _____

Insurance classification (for Life only) changes shall be made:

___ on next policy anniversary following the change of classification.

___ on _____

PREMIUM PAYMENT

Premiums shall be payable monthly (annually, semi-annually, quarterly, monthly or in such other modes as may then be permitted by the Company) in advance at the rate set forth.

Advance payment of $_____ is submitted with this application to be applied by the Company on premium for insurance when and if issued.

Coverage	Amount	Employer Contributions Per Person	Contributions required from Insured

IT IS AGREED THAT the insurance applied for shall not become effective until:

(a) this application is received and approved by Horace Mann Life Insurance Company at its Home Office in Springfield, Illinois and

(b) the minimum percentages as required by Horace Mann Life Insurance Company and/or the minimum number of lives required by law, of the Persons eligible have enrolled in the accepted coverages.

Dated at 1/10/92, this 10 day of January, 19 92.

BURLINGTON SCHOOL DISTRICT
(Full Name of Group Policyholder)

By _____ Superintendent
(Name and Title)

Phyllis W. Sattan 4997
(Signature of Agent and Agent Number)