TRUSTMARK INSURANCE COMPANY
"We, Us, and Our"
400 Field Drive
Lake Forest, IL 60045-2581
(800) 918-8877

DISABILITY INCOME PROTECTION CERTIFICATE

This is Your certificate of insurance (Certificate) while You are insured. It explains the rights and benefits that are determined by the Policy. The Policy is a contract between the Policyholder and Us.

We will pay the benefits set forth in this Certificate, which is made part of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect. A copy of the Policy is kept at Our home office, at the address listed above. You may inspect it during regular business hours.

This Certificate was issued on the basis that the information in Your application was correct and complete. If any information in the application was not correct, write to Us within 10 days of receipt of this Certificate. An error or omission may result in loss of coverage as of the Effective Date.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office, at the address listed above, or to Your agent within 30 days after the date You received it. The Certificate will then be canceled and any premium paid will be refunded.

Renewability: This Certificate is guaranteed renewable until the Certificate anniversary on or after Your 70th birthday. We will not change any provision of the Certificate except that We may change premium rates by class for all those insured under this form in Your state. In lieu of changing premium rates, We may change Definitions for all those insured under this form in Your state. Any rate change or Definitions change would first be approved by the appropriate governing authority in the state.

FURTHER INFORMATION REGARDING YOUR COVERAGE IS GIVEN ON THE PAGES THAT FOLLOW. THIS CERTIFICATE IS EVIDENCE OF YOUR COVERAGE. IT IS NOT THE INSURANCE POLICY.

YOUR COVERAGE IS INSURED AND UNDERWRITTEN BY TRUSTMARK INSURANCE COMPANY. ALL BENEFIT CLAIMS SHOULD BE SUBMITTED TO TRUSTMARK AND ALL QUESTIONS REGARDING YOUR COVERAGE SHOULD BE DIRECTED TO TRUSTMARK.

PLEASE READ YOUR CERTIFICATE CAREFULLY.
THIS CERTIFICATE CONTAINS LIMITED BENEFITS.

DISABILITY COVERAGE FOR ACCIDENTAL INJURIES AND SICKNESS

TRUSTMARK INSURANCE COMPANY

John Anderson
President

Laura A. Derouin
Corporate Secretary

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SCHEDULE

Certificate Number:	DIB49KY_[redacted]
Insured:	[redacted]
Effective Date:	[redacted]
Issue Age:	[redacted]
Initial Premium:	$[redacted]
Premium Payable:	[redacted]
Guaranteed Renewable Until:	Certificate anniversary following Your 70th birthday

Total Disability Benefit:	Weekly Benefit Amount:	$[redacted]
	Maximum Benefit Period:	26 weeks

Elimination Period:	Covered Accident -	[redacted]
	Covered Sickness -	[redacted]

DEFINITIONS

Active Employee
An Insured who meets all of the following requirements:

- Is working the minimum hours established by Your employer which must be at least 20 hours per week;
- Is receiving standard pay as set by the employment practices of Your employer or similar organizations; and
- Is a resident of the United States or its territories.

You will be considered to be an Active Employee on a paid vacation day or regular non-working day if You were an Active Employee on Your last regular working day. You are not considered an Active Employee if You are not performing Your Regular Occupation due to seasonal scheduling or You are on a company approved leave of absence.

Certificate
This booklet, including any attached applications for insurance, riders, Endorsements, or amendments describing Your insurance benefits.

Complications of Pregnancy
Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, hyperemesis gravidarum, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also means non-elective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy when a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, and similar conditions associated with the management of a difficult pregnancy and not constituting a distinctly diagnosed Complication of Pregnancy.

Covered Accident
An accident causing Injury which:

- Occurs after the Certificate Effective Date;
- Occurs while this Certificate is in force; and
- Is not excluded by name or specific description in this Certificate.

Covered Sickness
An illness, infection, disease, Normal Pregnancy, or Complications of Pregnancy not caused by an accident which:

- Occurs after the Certificate Effective Date;
- Occurs while this Certificate is in force; and
- Is not excluded by name or specific description in this Certificate.

Effective Date
The date coverage under this Certificate becomes effective. The Effective Date is shown on the Schedule or Endorsement.

Elimination Period
The number of continuous days You must be Totally Disabled before benefits become payable. The number of days is shown on the Schedule.

Endorsement
Any document that changes this Certificate's terms and conditions, benefit amounts, or premium due amounts.

Gainful Occupation
An occupation for which You are reasonably qualified and can perform based on Your education, training, and experience.

Injury
An accidental bodily injury:

- Which resulted from a Covered Accident; and
- For which You sought treatment from a Physician within 30 days of the date the Covered Accident occurred.

Insured
The person named as the Insured on the Schedule or Endorsement as having coverage under this Certificate.

Material and Substantial Duties
Duties that are normally required to perform an occupation and cannot be reasonably omitted or modified.

Maximum Benefit Period
The longest period of time for which benefits will be paid for a Covered Sickness or Covered Accident. The Maximum Benefit Period is shown on the Schedule, unless otherwise noted in the Benefit Provisions section. The Maximum Benefit Period begins after the Elimination Period is satisfied.

Medically Necessary
Treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of a sickness or Injury based upon generally accepted medical practices in the United States.

Mental Health Clinician
An individual who is licensed to conduct professional mental health assessments, provide counseling, case management, and psychotherapeutic services. This individual must be licensed in the state in which treatment is received, and is not You or Your spouse, or any of Your or Your spouse's children, parents, grandparents, grandchildren, brothers, sisters, or their respective spouses.

Mental Illness
A condition classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) except Substance Abuse. We will use the DSM most current as of the date of the loss. If the DSM is discontinued or replaced, We will use published data that, in Our opinion, provides the most comparable information.

The term Mental Illness does not include dementia, or other causes of cognitive impairment if due to:

- Stroke;
- Trauma;
- Viral infection;
- Alzheimer's disease or other dementing illness; or
- Other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar treatment

Normal Pregnancy
A pregnancy free of Complications of Pregnancy.

On the Job
While performing Your Regular Occupation for pay or benefits.

Physician
An individual who is licensed to practice medicine or surgery for the treatment of the condition in the state in which treatment is received, who is not You or Your spouse, or any of Your or Your spouse's children, parents, grandparents, grandchildren, brothers, sisters, or their respective spouses.

Policy
The group contract issued to the Policyholder. This Certificate is issued under the Policy and is made part of the Policy. Provisions of the Policy govern this Certificate.

Policyholder
The legal entity to which the Policy is issued.

Pre-existing Condition
A condition, whether diagnosed or not, for which symptoms existed within the 12 month period prior to the Effective Date; or for which medical advice or treatment was recommended or received from a Physician within 12 months prior to the Effective Date.

Recurrent Disability

Becoming disabled again for the same or related condition within 6 months after the end of a previous disability that was payable and covered under the terms of this Certificate.

Regular Occupation
Your usual job, profession, or activity for wages, compensation, or profit at the start of Your Total Disability.

Substance Abuse
Abuse of alcohol or any drug, narcotic, hallucinogen, or chemical substance, unless administered by a Physician and taken according to the Physician's instructions, or voluntarily ingesting any kind of poison or inhaling any kind of gas or fumes.

Total Disability or Totally Disabled
During the first 52 weeks of disability, up to the Maximum Benefit Duration if less, You are:

- Unable to perform all of the Material and Substantial Duties of Your Regular Occupation;
- Not engaged in any other occupation for wage or profit; and
- Under the regular and appropriate care of a Physician for such Total Disability.

After the first 52 weeks of disability, up to the Maximum Benefit Duration, if applicable, Total Disability means You are:

- Unable to perform all of the Material and Substantial Duties of any Gainful Occupation;
- Not engaged in any other occupation for wage or profit; and
- Under the regular and appropriate care of a Physician for such Total Disability.

Use of Alcohol
That which is defined and determined by the laws of the state where the loss or cause of loss was incurred.

You and Your
The Insured named on the Schedule.

We, Us, Our, or the Company
Trustmark Insurance Company.

Weekly Benefit Amount
The amount We will pay each week for Total Disability after the Elimination Period is satisfied. The Weekly Benefit Amount is shown on the Schedule.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION, AND CONTINUATION

Eligibility for Coverage

You are eligible for coverage if Your application is approved by Us and You are an Active Employee on the Effective Date of coverage.

Effective Date

Coverage will start at 12:00 a.m. standard time at Your home on the Effective Date shown on the Schedule.

Termination of Coverage

Your coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

- The end of the period for which premium is paid subject to the grace period;
- The premium due date following the date We receive Your written request to have Your insurance terminated;
- The Certificate anniversary on or next following Your 70th birthday;
- The date the Policy is terminated; or
- The date of Your death.

Suspension of Coverage During Military Service

If You enter into active duty status for any military service of the United States, or any other country, coverage is suspended as of the first date of active duty status. You must notify Us within 30 days of the first date of active duty status. When the Company receives notification of Your active duty status, any required adjustment of premium will be made, including refund of premium, if necessary.

Upon termination of active duty status, You may request a resumption of coverage if You still meet the eligibility requirements. This request must meet all of the following requirements:

- Be in writing;
- Be submitted to Us within 60 days of Your termination of active duty status; and
- Include the required premium.

Coverage will begin again on the date following termination of active duty status. Credit will be given for the Pre-existing Condition limitation period satisfied prior to the date of suspension.

BENEFIT PROVISIONS

Total Disability Benefit

We will pay the Total Disability benefit shown on the Schedule if You become Totally Disabled due to a Covered Accident or Covered Sickness. If You are disabled longer than the Elimination Period, We will pay benefits for as long as this coverage is in force, and You remain Totally Disabled, up to the Maximum Benefit Period, except as shown in the Geographical Limitations provision. We will calculate benefits on a daily basis. The daily benefit amount is 1/7th of Your Weekly Benefit Amount.

We will pay benefits for only one disability at a time, even if it is caused by more than one Covered Sickness and/or Covered Accident.

If You are not employed in Your Regular Occupation when You become Totally Disabled, We will pay the Weekly Benefit Amount for each week You cannot perform any Gainful Occupation. We will pay the Weekly Benefit Amount for each week You cannot perform such duties, up to the Maximum Benefit Period, while You remain Totally Disabled.

A Recurrent Disability will be treated as a continuation of the previous disability, not a new disability.

A Recurrent Disability does not require a new Elimination Period, and benefits will be paid to the Maximum Benefit Period for the combined periods of disability.

Total Disability resulting from a Normal Pregnancy is covered the same as any other Covered Sickness when such disability begins after the Certificate has been in effect for a period of 10 months or more from the Certificate Effective Date.

Total Disability resulting from a Mental Illness is covered the same as any other Covered Sickness.

Complications of Pregnancy: Total Disability resulting from Complications of Pregnancy is covered the same as any other Covered Sickness when such disability begins after the Certificate Effective Date. Benefits will not be paid if the Complications of Pregnancy are Pre-existing Conditions.

WAIVER OF PREMIUM

After 90 days of Total Disability, or after the Elimination Period shown on the Schedule, if longer than 90 days, We will waive the payment of premium for as long as benefits are payable.

After the Total Disability ends, or after the end of the Maximum Benefit Period, whichever is earlier, to keep this coverage in force, You must resume the payment of premium by paying the next premium due. Thereafter, the premium will be due and payable as provided in this Certificate.

EXCLUSIONS AND LIMITATIONS

Exclusions

No benefits will be paid for losses that are caused by or occur as the result of any of the following:

- A Pre-existing Condition as described and limited in this Certificate;
- Involvement in a war or act of war, declared or undeclared;
- Intentional self-inflicted injury or attempted suicide;
- Commission of or attempt to commit a felony or engagement in an illegal occupation;
- Participation in a riot;
- Being intoxicated or under the influence from Use of Alcohol, or any drugs, narcotics, or hallucinogens not prescribed by a Physician, or not used in the manner prescribed by the Physician;
- Substance Abuse as defined in this Certificate;
- Riding in or driving any vehicle in a race, stunt show, or speed test;
- Engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting, or any similar hazardous activities;
- Operating, learning to operate, serving as a crew member of, or jumping or falling from any aircraft, including those that are not motor driven. This does not include flying as a fare paying passenger;
- Having cosmetic surgery or other elective procedures that are not Medically Necessary;
- Loss of professional license, occupational license, or certification;
- Having an On the Job Injury or Sickness for which benefits are applied for and pending, paid, or payable if You applied or plan to apply, by worker's compensation or other similar occupational disease law.

Pre-existing Condition Limitation

No benefit will be paid for any condition caused by or resulting from a Pre-existing Condition which begins in the first 12 months after Your coverage Effective Date.

Geographical Limitation

If You become Totally Disabled due to a Covered Accident or a Covered Sickness while You are outside the United States or its territories and You are Totally Disabled longer than the Elimination Period, Your benefit period will be limited to 60 days. If You are still Totally Disabled when You return, We will resume payments starting from the date You return to the United States or its territories, up to the remaining Maximum Benefit Period.

PREMIUM

Payment of Premium

All premium, charges, or fees must be paid to Us at Our home office. All premium is payable in advance.

Due Date

The initial premium is due on the Effective Date of coverage. If the initial premium is not paid, there will be no coverage provided under this Certificate. Subsequent premium is due according to the "Premium Payable" time period shown on the Schedule. Failure to pay premium when due shall result in termination of coverage as of such due date, subject to the grace period.

Returned or Dishonored Payment

If a payment of any premium is dishonored for insufficient funds, a reasonable service charge shall be charged to You. A dishonored payment shall be considered a failure to pay premium.

Grace Period

If written notice of termination has not been received from You, a grace period of 31 days will be allowed for each premium payment due after the initial premium. Coverage shall remain in force during the grace period. If any premium is unpaid at the end of the grace period, coverage shall automatically terminate retroactively to the last day for which premium has been paid.

Reinstatement

If You do not pay premium by the end of the grace period, this coverage will no longer be in force. However, You may be able to put it back in force. This is called reinstatement. You may apply for reinstatement by submitting a reinstatement application with evidence of Your insurability. Such application must be in writing and submitted within 90 days from the date coverage ended. Reinstatement of coverage will be approved or disapproved within 45 days after Our receipt of the application. If We approve the application, reinstated coverage will become effective on the date We specify in an Endorsement. If We do not notify You that We have approved or disapproved the reinstatement application, this coverage will be reinstated on the 45th day after We receive Your completed reinstatement application.

The reinstated coverage will cover only disabilities that result from:

- Covered Accidents that occur after the effective date of reinstatement; or
- Covered Sicknesses which begin more than 10 days after the effective date of reinstatement.

In all other respects, the rights of all parties will remain the same, subject to any provisions noted on or attached to the reinstated coverage Endorsement. The statements in the application for the reinstated coverage will be measured from the date of reinstatement with respect to the time periods stated in "Time Limit on Certain Defenses" provision of the Certificate.

Premium Adjustment

We have the right to adjust the premium as described in this Certificate. Any premium adjustment will take effect on the next premium due date following the adjustment. Written notice of an adjustment will be mailed to You at least 30 days in advance.

We also have the right to change the premium on any premium due date following the effective date of any new or modified premium tax law applicable to this Certificate. The amount of such change will be determined by the amount of change in the premium tax imposed.

In order to implement any premium adjustment, We may elect to increase or decrease the benefits in lieu of any premium change. The new benefit will be the amount of coverage that Your premium could purchase after the premium adjustment. Any decrease in benefits would not occur until a signed acknowledgement of the decrease is received from You.

CLAIMS PAYMENT

Notice of Claim

We must receive written notice of claim within 90 days after a covered loss starts or as soon thereafter as reasonably possible.

Claim Forms

When We receive the notice of claim, We will send You forms for filing proof of loss. If these forms are not sent to You within 15 days, You will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the "Proof of Loss" section.

Proof of Loss

When this Certificate provides payment for continuing loss, written proof of loss must be completed and returned to Us within 90 days after the end of each period for which We owe You benefits. For any other loss, written proof must be given within 90 days after such loss or as soon thereafter as reasonably possible. We will not reduce or deny the claim for this reason, if the proof is submitted as soon as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after 1 year from the time specified. Proof of loss refers to all documentation necessary to support a claim.

Payment of Claims

After We receive written proof of loss and process Your claim, We will pay any benefits due. Benefits will be paid to You unless such benefits have been assigned. Any accrued benefits unpaid at Your death will be paid to Your estate.

Time of Payment of Claims

Once We have received the required proof of loss and approved Your claim, any benefits due under this Certificate will be paid within 30 days after We receive written proof of loss.

Fraudulent Claim Submission

If You knowingly submit or participate in the submission of a claim for benefits which contains false or misleading information that would have the effect of paying a benefit not otherwise payable, We shall have the right to rescind Your coverage back to the date the intentional or material misrepresentation was made. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

Medical Records and Examinations

With written authorization, We may obtain Your medical records. We have the right, at Our expense, to have You examined as often as reasonably necessary while a claim is pending. We have the right to have an autopsy performed, at Our expense, unless prohibited by applicable state law.

Termination of Benefits

Benefits will automatically end on the earliest of the following:

- The date You are no longer Totally Disabled;
- The date You fail to provide satisfactory proof of continuing Total Disability, when requested;
- The date You continue to be Totally Disabled beyond the Maximum Benefit Period shown on the Schedule; or
- The date of Your death.

GENERAL PROVISIONS

Entire Contract

This Certificate, including the Policy, Your application for coverage, any Endorsements, and any attached papers constitute the entire contract. No change shall be valid until approved by an executive officer of the Company and endorsed or attached to this Certificate. No agent has authority to change this Certificate or to waive any of its provisions.

Statements in the Application

All statements made in Your application, in the absence of fraud, are considered to be representations and not warranties. No statement made by You shall be used to contest coverage or reduce benefits unless both of the following occur:

- The statement is contained in an application; and
- A copy of the statement is furnished to You.

Time Limit on Certain Defenses

After coverage has been in force during a person's lifetime for 2 years from the Effective Date of coverage, only fraudulent misstatements in the application for this Certificate may be used to void it or to deny a claim for any loss after the 2 year period (hereinafter "Contestable Period"). This does not affect Our ability to void the Certificate or deny any claim during the first 2 years due to misstatement.

Any increase in coverage, addition to coverage, or reinstatement of coverage, as requested by application from You, shall begin a new 2 year Contestable Period for the amount of the increase, the additional coverage, or the reinstated coverage from the effective date of such increase, addition, or reinstatement of coverage.

When We contest the validity of the coverage of this Certificate, or any portion thereof, based on information given in the application for such coverage, We shall do so by a letter to You. Our contest of coverage is effective on the date We mail the letter including the refund of any applicable premium to You.

Misstatement of Age

If Your age is misstated in the application, any benefits payable will be those the premium You paid would have purchased at the correct age.

Legal Actions

No legal action may be brought against Us within 60 days after written proof of loss has been sent to Us. No such action may be brought more than 3 years from the time written proof of loss is required to be given.

Unpaid Premium

On payment of a claim under this Certificate, any premium then due and unpaid may be deducted therefrom.

Right to Recover Overpayments

We have the right to recover any overpayments made on Your claim due to fraud, an error the Company makes in processing Your claim, or Your receipt of income or wages from working during any period for which We have paid benefits to You.

We will notify You, in writing, of any overpayments made under this coverage. You must reimburse Us for any overpayments in full. We will determine the method by which the repayment is to be made, including the application of future benefits payable under this Certificate or attached rider to the overpayment balance. We will not recover more money than the amount We paid to You.

Conformity with State Laws

If any provision in this Certificate and any attached riders is in conflict with the laws which govern this Certificate and any attached riders, the provision will be deemed to be amended to conform with such laws.

Trustmark
benefits beyond benefits

New Voluntary Coverage Survey

Thank you for choosing Trustmark to provide your voluntary benefits! We are always looking for ways to improve the level of service you deserve. We would greatly appreciate it if you completed this short survey and returned it to us in the enclosed prepaid envelope. Should you have any questions regarding the survey, please contact us at (800) 918-8877 or email CustomerCare@trustmarksolutions.com.

1. Is this the first time you were offered voluntary coverage? ☐ Yes ☐ No

2. Please select one or more reasons for your purchase.
   - ☐ Estate planning
   - ☐ Affordability
   - ☐ Product design
   - ☐ Ease of payroll deduction
   - ☐ Re-enrollment
   - Other _____

3. How did you apply for your new policy?
   - ☐ In-person enrollment
   - ☐ Telephone
   - ☐ Self-service kiosk

4. When did you receive your policy?
   - ☐ 1 to 3 weeks after enrollment
   - ☐ 4 to 6 weeks after enrollment
   - ☐ 7 to 12 weeks after enrollment

5. Were you satisfied with the time it took to receive your policy? ☐ Yes ☐ No

6. How likely are you to recommend Trustmark to a friend, family member or colleague?

NOT AT ALL LIKELY										**VERY LIKELY**
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

7. If we need to get in touch with you, how would you prefer to receive future communications?
   - ☐ Phone _____
   - ☐ Email _____
   - ☐ Mail _____

8. Did the overall customer experience meet your expectations? ☐ Yes ☐ No

   Optional:
   If you answered no, please provide us with your contact information if you would like to discuss your experience.

   Name (please print): _____ Telephone: _____

   Email: _____ Best time to call: _____

9. Additional comments/feedback: