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**GROUP  
BENEFIT  
PLAN**

WESLEYAN  
UNIVERSITY

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Some of the terms used within this Booklet-certificate are capitalized and have special meanings. Please refer to the definitions at the end of this Booklet-certificate when reading about Your benefits.

## SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

The Policyholder: WESLEYAN UNIVERSITY  
The Policy Number: GL-674967  
Policy Effective Date: January 1, 2004  
Anniversary Date: January 1 of each year, beginning in 2005.

### Who is eligible for coverage?

Eligible Class(es): All Active Employees who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees as follows:

Class 1: All Active Full-time Administrative Staff who work three-quarters time based on a 37.5 hour work week and All Active Part-time Faculty Members and Librarians who work half-time based on a 37.5 hour work week

Class 2: All Active Full-time Secretarial and Clerical Employees who work three-quarters time based on a 35 hour work week

Class 3: All Active Full-time Physical Plant Employees who work three-quarters time based on a 40 hour work week

Class 4: All Active Full-time Employees earning \$150,000 or more annually

All persons who are insured for employee coverage will be eligible for coverage for Dependents.

### When will You become eligible? (Eligibility Waiting Period)

You are eligible on the later of either the Policy Effective Date or the date You enter an eligible class.

Retirees are eligible for coverage on the later of:

1. the date on which the individual meets the definition of a Retiree; or
2. the Policy Effective Date.

### When will You become eligible for Dependent Coverage?

You will become eligible for Dependent coverage on the later of:

1. the date You become eligible for employee coverage; or
2. the date You acquire Your first Dependent.

### What is the Guaranteed Issue Amount?

This is the Amount of Insurance for which We do not require Evidence of Good Health. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

### What is Evidence of Good Health?

Evidence of Good Health is information about a person's health from which We can determine if coverage or increases in coverage will be effective. Information may include questionnaires, physical exams, or written documentation as required by Us.

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**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
Hartford, Connecticut  
(Herein called Hartford Life)

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**CERTIFICATE OF INSURANCE**

Under  
**The Group Insurance Policy**  
As of the  
**Effective Date**  
Issued by  
**HARTFORD LIFE**  
to  
**The Policyholder**

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This is to certify that We have issued and delivered the Group Insurance Policy (Policy) to the Policyholder. The Policy insures the Policyholder's employees who:

- are eligible for the insurance;
- become insured; and
- continue to be insured,

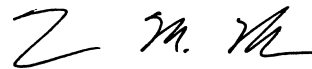
according to the terms of the Policy.

The terms of the Policy which affect an employee's insurance are summarized in the following pages.

This Certificate of Insurance, and the following pages, will become Your Booklet-certificate. The Booklet-certificate is a part of the Policy. This Booklet-certificate replaces any other which We may have issued to the Policyholder to give to You under the Policy specified herein.



Christine Hayer Repasy, *Secretary*



Thomas M. Marra, *President*

Inquiries as to the status of Your submission of Evidence of Good Health should be addressed to Your Employer and/or Benefit Administrator. We, Your Employer and/or Benefit Administrator will notify You of approvals. We will notify You, in writing, of any disapprovals.

**When will Evidence of Good Health be required?**

Evidence of Good Health is required if:

1. You enroll for coverage more than 31 days after the date You are first eligible to do so for any amount of Life Insurance for Yourself or Your Spouse; or for an Amount of Life Insurance in excess of \$15,000 for a Dependent child; or
2. You elect no coverage when eligible to do so and later opt for coverage for any Amount of Life Insurance for Yourself or Your Spouse; or for an Amount of Life Insurance in excess of \$15,000 for a Dependent child.

Evidence of Good Health must be provided at Your own expense.

If Evidence of Good Health is not approved in the situation(s) described above, no coverage, including the Guaranteed Issue Amount, will become effective.

Evidence of Good Health is also required if You elect to increase coverage for Yourself or Your Dependents to any higher option or increment level. This requirement is waived for each of Your Dependent children whose new Amount of Life Insurance is \$15,000 or less.

Evidence of Good Health is also required the first time Your or Your Dependents Amount of Life Insurance would exceed the Guaranteed Issue Amount for any coverage.

If Evidence of Good Health is not approved in this situation, You and Your Dependents are eligible for the amount You requested for which Evidence of Good Health was not required.

Additionally, once approved, Evidence of Good Health will be required again only if Your or Your Dependents Amount of Life Insurance is greater than the Guarantee Issue Amount and You increase Your or Your Dependents coverage election.

**Are there exceptions to the Evidence of Good Health requirement for late enrolling Dependents?**

This Evidence of Good Health requirement will be waived for Your Dependent spouse and/or Dependent children, if:

1. You do not elect coverage for Your spouse when first eligible to do so, but, within 31 days following the date You acquire Your first child, You elect spouse coverage; or
2. Your spouse and children were previously covered for life benefits provided by Your spouse's employer group plan; and
  - a) Your spouse and children have ceased to be covered under the employer's group plan due to Your spouse's loss of employment or cancellation of that group plan;
  - b) Your spouse and children provide Us with proof of prior coverage, including the date of termination, when applying for Dependent Coverage; and
  - c) coverage with Us is requested within 31 days of Your spouse's loss of coverage.

This Evidence of Good Health requirement will be waived for Dependent children whose Amount of Life Insurance is \$15,000 or less.

Dependents who qualify for this waiver will be subject to all other conditions, restrictions and limitations of the Policy.

**AMOUNT OF LIFE INSURANCE  
Employee and Retiree Only**

**What Life benefits are available to You?**

**Basic Amount of Life Insurance:**

An amount equal to 1 times Your annual rate of basic Earnings, rounded to the next higher multiple of \$1,000, subject to a maximum of \$50,000.

In no event however will Your Basic Amount of Life Insurance be less than \$10,000.

**Supplemental Amount of Life Insurance:**

- a) a Guaranteed Issue Amount equal to the lesser of 1, 2, 3, 4 or 5 times Your annual rate of basic Earnings or \$200,000 without Evidence of Good Health; or
- b) a maximum amount equal to 1, 2, 3, 4 or 5 times Your annual rate of basic Earnings, subject to a maximum of \$750,000 with Evidence of Good Health,

rounded to the next higher multiple of \$1,000, if not already such a multiple.

In no event however will Your Supplemental Amount of Life Insurance be less than \$10,000.

**What Life benefits are available to Retirees?**

With respect to Early Retirees:

**Amount of Life Insurance:**

The Amount of Insurance which was in effect for You on Your last day as an Active Full-time Employee just prior to Your date of retirement.

With respect to Retirees:

**Amount of Life Insurance:**

An amount equal to \$5,000.

**Are there other limitations which apply to Amounts of Life Insurance for Employees and Retirees?**

The Amount You elect is indicated on Your group enrollment form.

Your Amount of Life Insurance will be reduced by any life benefit:

- 1. paid to You under an accelerated death benefit in the Prior Plan; and
- 2. in force for You under any disability extension provision of the Prior Plan.

**If You convert, does it affect the Amount of Life Insurance benefit payable?**

The Amount of Life Insurance under the Policy will be reduced by the amount of the individual life insurance issued in accordance with the Conversion Privilege for reasons other than reductions in coverage.

**REDUCED AMOUNTS OF INSURANCE**

**What reductions in Your coverage will occur due to Your age?**

With respect to All Active Full-time Employees and Early Retirees:

Your Amount of Life Insurance will decrease by 65% on the Anniversary Date which occurs on or next follows the date You attain age 65 and again when You attain age 70. The reduction will apply to the Amount of Life Insurance in force immediately prior to that Anniversary Date.

Additionally, if:

- 1. You become insured under the Policy; or
- 2. Your coverage increases,

on or after the date You attain age 65, We reduce the amount of coverage for which You would otherwise be eligible in the same manner.

Reduced amounts of Life Insurance will be rounded to the next higher multiple of \$500, if not already such a multiple.

**AMOUNT OF LIFE INSURANCE  
Dependent Only**

**What Life benefits are available to Your Dependents?**

**NOTE: RETIREES ARE NOT ELIGIBLE FOR DEPENDENT COVERAGE.**

**Supplemental Dependent Spouse:**

- a) a Guaranteed Issue amount You elect in increments of \$10,000, subject to a maximum of \$30,000 without Evidence of Good Health, not to exceed 50% of the Supplemental Amount of Life Insurance in force for the employee; or
- b) a maximum amount You elect in increments of \$10,000, subject to a maximum of \$100,000 with Evidence of Good Health, not to exceed 50% of the Supplemental Amount of Life Insurance in force for the employee.

**Supplemental Dependent Children:**

- 15 day(s) but less than 6 month(s) of age: \$100
- 6 month(s) of age or older: \$5,000

The Amount You elect is indicated on Your group enrollment form.

**ELIGIBILITY AND ENROLLMENT**

**Must You contribute toward the cost of coverage?**

With respect to Basic Life Insurance coverage, You do not contribute toward the cost.

With respect to Supplemental Life Insurance and Supplemental Dependent Life Insurance coverage, You must contribute toward the cost.

**How do You enroll?**

To enroll You must:

- 1. complete and sign a group insurance enrollment form which is satisfactory to Us; and
- 2. deliver it to the Employer.

If You do not enroll within 31 days after becoming eligible, the following limitations will apply to a later enrollment:

- 1. You must submit Evidence of Good Health; and
- 2. You may not enroll until:
  - a) an Annual Enrollment Period; or
  - b) You have a Change in Family Status.

Any such enrollment must be made during the Annual Enrollment Period or within 31 days of the Change in Family Status.

The Annual Enrollment Period is determined by Your Employer on a yearly basis.

**What constitutes a Change in Family Status?**

A Change in Family Status means:

- 1. Your marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
- 2. the death of or divorce from Your spouse;
- 3. the death of or emancipation of a child;
- 4. spouse's loss of employment which results in a loss of group insurance; or
- 5. change in classification from Part-time to Full-time or from Full-time to Part-time.

**When does coverage start?**

Your coverage will start on the latest of the dates determined below:

1. the date You become eligible, if You enroll or have enrolled by then;
2. the date on which You enroll, if You do so within 31 days after the date You are eligible;
3. the date We approve Evidence of Good Health which We may have required; or
4. the first day of the month following the Annual Enrollment Period if You enroll during an Annual Enrollment Period.

All of the above effective dates are subject to the Deferred Effective Date provision.

**What is the Deferred Effective Date provision for Retirees?**

If a Retiree is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of any increase or additional benefit will be deferred until the Retiree is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

"Confined elsewhere" means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

**What is the Deferred Effective Date provision for employees?**

If You are absent from work due to a physical or mental condition on the date Your insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of Your insurance, any increase in insurance or the additional benefit will be deferred until the date You return to work as an Active Full-time Employee.

**Are there exceptions to the Deferred Effective Date provision?****NOTE: NOT APPLICABLE TO RETIREES**

If You were actively at work or on an approved leave of absence in conformity with the Family or Medical Leave Act of 1993, and insured under the Prior Plan on the day before the Policy Effective Date and You would be eligible for coverage on the Policy Effective Date except that You are not able to meet the requirements of the Deferred Effective Date provision, then:

1. the Deferred Effective Date provision will not apply to the original effective date of coverage; and
2. the coverage amount shown in the Schedule of Insurance will not apply to You.

Instead, You will be considered to be insured and your coverage amount will be the lesser of:

1. the Amount of Life Insurance under the Prior Plan; or
2. the Amount of Life Insurance shown in the Schedule of Insurance,

reduced by:

1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.

You will remain insured under this provision until the first to occur of:

1. the date You return to work as an Active Full-time Employee;
2. the date Your insurance terminates for a reason stated under the Termination provision;
3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or
4. the last day You would have been covered under the Prior Plan, had the Prior Plan not terminated.

**When does coverage for Your Dependent(s) start?**

You are required to enroll for contributory Dependent coverage. To do so You have to complete and sign a group insurance enrollment form acceptable to Us and deliver it to the Employer.

Your spouse will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:

1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for spouse coverage by then; or
2. the date You enroll for Dependent Coverage, if You do so within 31 days after the date You are eligible.

If You enroll for Dependent Coverage more than 31 days after You are first eligible to do so, no coverage will be available without Evidence of Good Health.

Coverage for which We require Evidence of Good Health will be effective on the later of:

1. the date You become eligible; or
2. the date approved by Us.

Each child will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:

1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for child coverage by then; or
2. the date You enroll for coverage for Your child, if You do so within 31 days after the date You acquire the child.

If You enroll for Dependent Coverage more than 31 days after You are first eligible to do so, no coverage will be available without Evidence of Good Health.

Coverage for which We require Evidence of Good Health will be effective once approved by Us.

In no event will Dependent Coverage become effective before the date You become insured.

All effective dates of coverage are subject to the Deferred Effective Date provision for Dependents.

#### **What is the Deferred Effective Date provision for Dependents?**

If a Dependent, other than a newborn, is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of insurance, any increase or additional benefit will be deferred until the Dependent is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

"Confined elsewhere" means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

#### **When are changes effective?**

The provisions, terms and conditions of the Schedule of Insurance or this Booklet-certificate may be modified, amended or changed at any time; consent from any covered individual is not required.

If there is any type of change in Your class, Earnings, the Schedule of Insurance or the Booklet-certificate which:

1. decreases an amount of coverage or deletes, limits or restricts the availability of a benefit or provision, then that decrease, deletion, limitation or restriction will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective;
2. increases an amount of coverage or adds, improves or increases availability of a benefit or provision, then that increase, addition or improvement will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective, subject to application of the Deferred Effective Date provision and Our approval where Evidence of Good Health is required.

## **BENEFITS**

### **Life Insurance Benefit**

#### **To whom and how are benefits paid?**

A completed claim form, a certified copy of the death certificate and Your enrollment form must be sent to the Employer or Us. When the required claim papers are received and approved by Us, the Amount of Life Insurance will be paid.

Benefits payable for a Dependent's death are payable to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

Your death benefit will be paid in a lump sum to the beneficiary(ies) designated by You in writing and on file with the Employer.

Unless You have requested something different, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before You, His share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1. up to \$500 of Your life insurance to any party that We deem is entitled because of their payment of burial expenses. We will be released from further liability for any amount so paid; and/or
2. the executors or administrators of Your estate; or
3. Your surviving relatives in the following order:
  - a) all to Your surviving spouse; or
  - b) if Your spouse does not survive You, in equal shares to Your surviving children; or
  - c) if no child survives You, in equal shares to Your surviving parents.

If a minor does not have a legal guardian, We may, until such a guardian is appointed, pay the person We deem to be caring for and supporting him. Such payment will be in monthly installments of not more than \$200.

If a death benefit payable meets Our guidelines, then the benefit is payable into a checking account. In the case of a Dependent death benefit, You own the checking account. In the case of Your death benefit, Your beneficiary owns the checking account. A lump sum payment may be elected by writing a check for the full amount in the checking account.

#### **What benefit is payable if Your death results from suicide?**

No Supplemental Life or Supplemental Dependent Life benefit will be payable if death results from suicide, whether sane or insane, within 2 years of the effective date of Your coverage. Additionally, if death resulting from suicide, whether sane or insane, occurs within 2 years of the effective date of an increase in Your coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 2 year period includes the time coverage was in force under a Prior Plan.

### **Accelerated Death Benefit**

**This benefit is not available for Retirees.**

#### **What is the benefit?**

If You are or Your Dependent is diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and that person is:

1. less than Normal Retirement Age; and
2. insured for at least \$10,000,

then You may request that a portion of that person's Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of \$3,000 and a maximum of \$500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to \$20,000 and You are Terminally Ill, You can request any portion of the life insurance between \$3,000 to \$16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only \$3,000 now, You cannot request the additional \$13,000 in the future.

**What does Terminal Illness/Terminally Ill mean?**

Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

**RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.**

**What if an individual is no longer Terminally Ill?**

If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

**What limitations apply to this benefit?**

The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

**What if You made an assignment under this plan?**

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

**TERMINATION  
Employee and Retiree Coverage**

**When does Your coverage terminate?**

Unless continued in accordance with the Exceptions to Termination section, Your insurance will terminate on the first to occur of:

1. the date the Policy terminates;
2. the last day of the period for which You made any required premium contribution, if You fail to make any further required contribution;
3. the date You are no longer in a class eligible for coverage;
4. the date Your Employer terminates Your employment; or
5. the date You are absent from work as an Active Full-time Employee.

The Policyholder is required by the laws of the State of Connecticut to give You written notice of the termination of the Policy at least 15 days before it happens. This is required even if the terminated Policy is replaced by another group policy.

**EXCEPTIONS TO TERMINATION**

**Under what conditions can Your insurance be continued under the continuation provisions?**

If You are absent from work as an Active Full-time Employee, Your insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:

1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

If You are on a documented leave of absence, other than Family or Medical Leave, all of Your coverages (including Dependent Life coverage) may be continued until the last day of the month following the month in which the leave of absence commenced.

If You are laid off due to lack of work, all of Your coverages (including Dependent Life coverage) may be continued until the last day of the month following the month in which the layoff commenced.

If Your employment status changes from Full-time to Part-time, all of Your coverages (including Dependent Life coverage) may be continued for 3 consecutive month(s) following the date of such change in employment status.

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, all of Your coverages (including Dependent Life coverage) may be continued for up to 12 weeks, or longer if required by state law, following the date Your insurance would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for You must be paid;
3. Your benefit level will be that which was in effect on the day before said leave started, subject to any reductions included in the Policy;
4. the amount of Earnings upon which Your benefit may be based, will be that which was in effect on the day before said leave started; and
5. continued coverage will cease immediately if one of the following events should occur:
  - a) the leave terminates prior to the agreed upon date;
  - b) the Policy terminates;
  - c) You or the Policyholder fail to pay premium when due; or
  - d) the Policy no longer insures Your class.

In all other respects, the terms of Your insurance remain unchanged.

If You are absent from work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued until the last day of a period of 12 month(s) which begins on the date You were first absent from work as an Active Full-time Employee. If You feel that Your condition may continue for an extended period of time, You should request that Your Employer file a waiver of premium claim.

#### **What is a disability extension?**

A disability extension is a provision which allows for continued employee life insurance while You are Disabled. Premium for Your continued coverage will be required. This provision does not apply to Retirees

If You meet the conditions below, We will pay a death benefit when We receive proof of Your death. The Amount of Life Insurance payable will be the Amount of Life insurance in force on the date You ceased to be an Active Full-time Employee, subject to any age reductions provided by any other part of the Policy.

#### **To what coverages does the disability extension apply?**

The disability extension applies only to Your Life Insurance. This provision does not apply to any Dependent Life or AD&D coverages, if included herein.

#### **What conditions must be satisfied before You qualify for disability extension?**

1. You must be less than age Normal Retirement Age, insured and Disabled; and
2. We must continue to receive premium for Your coverage.

#### **How long will coverage be continued?**

Your coverage will continue until the first to occur of:

1. the date the Policy terminates;
2. the date the required premium for Your coverage is not paid to Us;
3. the date You attain age Normal Retirement Age; or
4. the date You are no longer Disabled.

**What does Disabled mean?**

Disabled means that You have a condition that prevents You from doing any work for which You are or could become qualified by education, training or experience.

**What if You are no longer Disabled?**

If, for any reason, You are no longer Disabled, and:

1. You return to work in an Eligible Class, then all of Your coverages will be reinstated subject to the terms of the Policy in effect on the reinstatement date; or
2. You do not return to work within an Eligible Class, and You are not eligible for any other group life insurance, then You are entitled to the Conversion Privilege. You may convert the Amount of Life Insurance that is in force for You on the date it is determined that You are no longer Disabled.

**DEPENDENT COVERAGE****When does Dependent Coverage terminate?**

Unless continued in accordance with the Exception to Termination section, a covered Dependent's insurance will terminate on the earliest of:

1. the date Your coverage terminates;
2. the last day of the period for which any required premium contribution is made, if You fail to make any further required contribution;
3. the date You are no longer eligible for Dependent Coverage;
4. the date the Dependent no longer meets the definition of Dependent; or
5. the date We or the Employer terminate Dependent Coverage.

**EXCEPTIONS TO TERMINATION****Under what conditions can Dependent child insurance be continued?**

If a covered Dependent child reaches the age at which He would otherwise cease to be a Dependent as defined, and the Dependent child is:

1. disabled and incapable of earning His own living; and
2. unmarried and primarily dependent on You for support and maintenance,

then Dependent coverage will not terminate solely due to age if You submit satisfactory proof of the Dependent child's disability to Us within 31 days of the date the Dependent child reaches such age.

Coverage will continue while the Policy remains in force as long as:

1. the child continues to meet the required conditions; and
2. any required premium is paid.

We will have the right to require satisfactory proof that the child continues to meet the required conditions as often as necessary during the first two years of continuation, but not more than once a year after that.

## PORTABILITY

### **When can a person elect Portability?**

You may elect portability if:

1. the Policy is still in force;
2. Your life insurance terminates because:
  - a. Your employment terminates for any reason prior to Retirement; or
  - b. You are no longer in an Eligible Class; and
3. You do not currently have coverage for the amount of life insurance You intend to continue under a certificate of insurance issued in accordance with a conversion, portability or other similar provision under this Policy.

A Dependent may elect portability if:

1. the Policy is still in force;
2. He has not reached Retirement status; and
3. His life insurance terminates because:
  - a. Your employment terminates for any reason prior to Retirement;
  - b. Your membership in a class eligible for Dependent's coverage ceases;
  - c. You die; or
  - d. He ceases to be an eligible Dependent as defined, except a child who reaches the limiting age under the Policy.

In order for a Dependent child to continue coverage, You and/or Your spouse must elect continuation.

### **What does Retirement mean?**

Retirement means the date You or Your Dependent attain normal retirement age under the 1983 United States Social Security Act, and any amendments thereto.

### **Will Conversion be available if a person elects to continue coverage under this Portability provision?**

If a person elects to continue all terminated coverage under this portability provision, then the Conversion provision is not available. If a person elects to continue only a portion of terminated coverage under this portability provision, then the Conversion privilege will be available for the remaining amount.

### **How is Portability elected?**

A person must, within 31 days of the date group coverage terminates:

1. make written application to Us; and
2. pay the required premium.

If this is done, We will issue a certificate of insurance under a group portability policy. Such coverage will be:

1. issued without evidence of good health;
2. on one of the forms then being issued by Us for portability purposes; and
3. effective on the day following the date insurance terminates.

The terms and conditions of coverage under the group portability policy will be similar, but may not be identical, to coverage under this plan.

### **What limitations apply to this benefit?**

A person may elect to continue 50%, 75% or 100% of his amount of life insurance being terminated. Such amount will be rounded to the next higher \$1,000, if not already an even multiple thereof. No employee's amount of life insurance continued may exceed \$250,000. No spouse's amount of life insurance continued may exceed \$50,000. No child's amount of life insurance continued may exceed \$10,000.

If an election is made to continue 50% or 75% now, a person may not continue any portion of the remaining amount. In no event will a person be able to continue an amount of life insurance which is less than \$5,000 unless he is a Dependent child.

**How much does Portability cost?**

See Your Employer for the cost.

## CONVERSION PRIVILEGE

**When can an individual convert?**

If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

If the qualifying event is policy termination or termination of coverage for a class then the individual must have been insured for at least 5 years under the Policy in order to be eligible for this conversion privilege.

**What is the conversion policy?**

The conversion policy will:

1. be on one of the life insurance policy forms, except term insurance, then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

**How much can be converted?**

If the qualifying event is policy termination or termination of coverage for a class, then the amount which may be converted is limited to the lesser of:

1. the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which the individual becomes covered within 31 days of termination of group coverage; or
2. \$2,000.

If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

**How does an individual convert coverage?**

To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to Us and pay the premium required for his age and class of risk.

**What if death occurs during the conversion election period?**

If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

## GENERAL PROVISIONS

**When can this plan be contested?**

Except for non-payment of premium, the Policy cannot be contested after two years from the Policy Effective Date.

No statement relating to insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the individual's lifetime. In order to be used, the statement must be in writing and signed by the affected individual.

**Who interprets policy terms and conditions?**

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

**Are there any rights of assignment?**

You have the right to absolutely assign all of Your rights and interest under the Policy including, but not limited to, the following:

1. the right to make any contributions required to keep the insurance in force;
2. the privilege of converting; and
3. the right to name and change a beneficiary.

No absolute assignment of rights and interest shall be binding on Us until and unless:

1. the original of the form documenting the absolute assignment; or
2. a true copy of it,

is received and acknowledged by Us at our home office.

We have no responsibility:

1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.

### **How do You designate or change Your beneficiary?**

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

### **What recourse do You have if Your claim is denied?**

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
  - b) 60 days of receipt of claim denial for all other claims; and
2. you may request copies of all documents, records, and other information relevant to your claim; and
3. you may submit written comments, documents, records, and other information relating to your claim.

We will respond to you in writing with our final decision on your claim.

## **DEFINITIONS**

**Active Full-time Employee** – An employee who works for the Employer on a regular basis in the usual course of the Employer's business. An employee must work at least the number of hours in the Employer's normal work week. This must be at least 40 hours. You will be considered actively at work with Your Employer on a day which is one of Your Employer's scheduled work days if You are performing, in the usual way, all of the regular duties of Your job on a Full-time basis on that day. You will also be considered actively at work on a paid vacation day or a day which is not one of Your Employer's scheduled work days only if You were actively at work on the preceding scheduled work day.

**Amount of Life Insurance** – This term means both the Basic and Supplemental Life Amounts unless otherwise stated in specific provisions and benefits.

**Anniversary Date** – The date occurring in each calendar year which is an anniversary of the Policy Effective Date.

### **Dependent**

1. Your spouse; and
2. Your unmarried child who is:
  - a) at least 15 day(s) old but not yet 19 years old; or
  - b) 19, but has not yet attained age 23, is primarily dependent upon You for financial support and attends an accredited school (other than a correspondence school) on a regular and Full-time student basis as his principal activity; or
  - c) 19 years old or older, and is disabled and primarily dependent upon You for financial support. Such child must have become disabled before attaining age 19.

The term "Full-time student" shall mean registered for not less than 12 course credit hours per semester. If the institution establishes Full-time student status by a method other than semester credit hours, We reserve the right to determine whether the student qualifies as a Dependent.

The term "child", shall also include Your:

1. stepchild;
2. legally adopted child; and
3. any other child related to You by blood or marriage and who lives with You in a regular parent-child relationship, provided that You claim such child as a dependent on Your most current federal income tax return Form 1040.

You may not elect coverage for Your Dependent if Your Dependent is covered as an employee under the Policy. Any person who is in Full-time military, naval or air force service cannot be a Dependent. No person can be insured as a Dependent of more than one employee under the Policy.

**Earnings** - Regular pay, not counting:

1. commissions;
2. bonuses;
3. overtime pay; or
4. any other pay or fringe benefits.

**Employer** – The Policyholder named in the Schedule of Insurance.

**He/His** – He or she. His or her.

**Normal Retirement Age** – The Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth.

**Prior Plan** – A plan of group term life insurance sponsored by the Employer which was in force on the day before the Policy Effective Date.

Faculty:

**Retiree**

**Early Retiree** – A former Active Full-time Employee of the Employer who:

- is between the ages of 59 and 68; and
- who has completed at least 10 years of Active Full-time service with the Employer.

**Retiree** – A former Active Full-time Employee of the Employer who:

- is 69 years of age or older; and
- who has completed at least 10 years of Active Full-time service with the Employer.

Non Faculty:

**Retiree**

**Early Retiree** – A former Active Full-time Employee of the Employer who:

- is between ages 55 and 65;
- retires on or after age 55; and
- whose age plus years of service equals at least 75.

**Retiree** – A former Active Full-time Employee of the Employer who:

- is 66 years of age or older;
- who retires on or after age 55; and
- whose age plus years of service equals at least 75.

**We/Us/Our** – The Hartford Life and Accident Insurance Company.

**You/Your** – The employee to whom this Booklet-certificate is issued.

**ERISA INFORMATION**

**THE FOLLOWING NOTICE  
CONTAINS IMPORTANT INFORMATION**

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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**1. Plan Name**

Group Long Term Disability, Life and Supplemental Life Plan for employees of WESLEYAN UNIVERSITY

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**2. Plan Number**

511

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**3. Employer/Plan Sponsor**

WESLEYAN UNIVERSITY  
212 College Street  
Middletown, CT 06457

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**4. Employer Identification Number**

06-0646959

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**5. Type of Plan**

Welfare Benefit Plan providing Group Long Term Disability, Life and Supplemental Life.

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**6. Plan Administrator**

WESLEYAN UNIVERSITY  
212 College Street  
Middletown, CT 06457

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7. **Agent for Service of Legal Process**

For the Plan

WESLEYAN UNIVERSITY  
212 College Street  
Middletown, CT 06457

For the Policy:

Hartford Life And Accident Insurance Company  
200 Hopmeadow St.  
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

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## STATEMENT OF ERISA RIGHTS

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

### 1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### 2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### 4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **CLAIM PROCEDURES**

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

### **Claim Procedures for Claims Requiring a Determination of Disability**

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

#### Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

### **Claim Procedures for Claims Not Requiring a Determination of Disability**

#### **Claims for Benefits**

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

## Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

**The Plan Described in this Booklet  
is Insured by the**

**Hartford Life and Accident Insurance Company**  
Hartford, Connecticut

**Member of The Hartford Insurance Group**

