120 Royall Street, Canton, Massachusetts 02021

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

GROUP LONG TERM DISABILITY INCOME INSURANCE POLICY
NON-PARTICIPATING

GROUP POLICYHOLDER:	**TOWN OF WAYLAND**
GROUP POLICY NUMBER:	**G-54784**
GROUP POLICY EFFECTIVE DATE:	**NOVEMBER 1, 2018**
GROUP POLICY ANNIVERSARY DATE:	**JULY 1, 2019**
GOVERNING JURISDICTION:	**COMMONWEALTH OF MASSACHUSETTS**

Boston Mutual Life Insurance Company (referred to as We, Our, Us) will provide benefits under this policy. We make this promise subject to all of this policy's provisions.

The **Policyholder** should read this policy carefully and contact Boston Mutual Life Insurance Company promptly with any questions. This policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This entire policy consists of:

1. all policy provisions and any amendments and/or attachments issued;
2. the Certificate of Coverage; and
3. the **Policyholder's** signed application; and if applicable,
4. the **insured persons'** signed **enrollment forms**.

This policy may be changed in whole or in part. Only an officer of Boston Mutual Life Insurance Company can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Boston Mutual Life Insurance Company at its home office in Canton, MA on the Policy Effective Date.

John Rubén Flores

Secretary

President

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POLICYHOLDER PROVISIONS

INCONTESTABILITY

The validity of the policy shall not be contested after the policy has been in effect for two years except in situations when:

1. premium has not been paid; or
2. for fraudulent misrepresentations.

COST OF INSURANCE

The initial premium for the policy is based on the initial rate(s) shown below.

Option 1:

Age	Monthly rate per $100 of **monthly benefit**
Less than age 25	0.250
25-29	0.326
30-34	0.490
35-39	0.643
40-44	0.797
45-49	1.085
50-54	1.402
55-59	1.709
60 and over	1.853

Option 2:

Age	Monthly rate per $100 of **monthly benefit**
Less than age 25	0.144
25-29	0.211
30-34	0.326
35-39	0.442
40-44	0.557
45-49	0.778
50-54	1.000
55-59	1.200
60 and over	1.277

INITIAL RATE GUARANTEE AND RATE CHANGES

A change in premium rates will not take effect before 07/01/2020.

However, **we** may change premium rates at any time for reasons which affect the risk assumed, including but not limited to those reasons shown below:

1. a change occurs in this policy design;
2. the number of **insureds** changes by 25% or more; or
3. a new **law** or a change in any existing **law** is enacted which applies to this policy.

We will notify the **Policyholder** in writing at least 31 days before a premium rate is changed. A change may take effect on an earlier date when both the **Policyholder** and **we** agree.

WHEN PREMIUM IS DUE

Premium Due Dates: 11/01/2018 and the 1st of each calendar month thereafter.

The **Policyholder** must send all premiums to **us** on or before their respective due date. The premium must be paid in United States dollars.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

Premium charges for new **insured persons** or for increases in insurance amounts will begin on the premium due date which coincides with or next follows the date of the addition or the change. Premium charges for terminated persons will end, and decreases for insurance amounts will begin, on the premium due date which coincides with or next follows the termination or the change in amount. This method of charging premium will neither commence any insurance after the date it would otherwise begin nor extend any insurance coverage beyond the date it would otherwise terminate pursuant to the applicable effective date or termination provisions of the policy.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

We will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WAIVER OF PREMIUM

We do not require premium payment while the **insured person** is receiving Long Term Disability payments under this policy.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The **Policyholder** must provide **us** with the following on a regular basis:

1. information about persons:

   a. who are eligible to become insured; and
   b. who **enroll** for coverage and their initial amount of coverage;
   c. whose amounts of coverage change; and
   d. whose coverage ends;

2. occupational and salary information and any other information that may be required to manage a claim; and

3. any other information that may be reasonably required.

Policyholder records that have a bearing, in **our** opinion, on this policy will be available for review by **us** at any reasonable time as determined by **us**.

INFORMATION PROVIDED BY US

We will furnish the **Policyholder** with a Certificate of Coverage which outlines the benefits under this policy. The **Policyholder** will make available a Certificate of Coverage to **insured persons**.

AMENDING OR CANCELING THE POLICY

This policy can be canceled:

1. by **us**; or
2. by the **Policyholder**.

We may amend or cancel this policy if:

1. there is less than 25% participation of those eligible persons who pay all or part of their premium for the policy;
2. there is less than 100% participation of those eligible persons for a **Policyholder** paid plan;
3. the **Policyholder** does not promptly provide **us** with information that is reasonably required;
4. the **Policyholder** fails to perform any of its obligations that relate to this policy;
5. fewer than 10 persons are insured under the policy;
6. the premium is not paid in accordance with the provisions of this policy;
7. the **Policyholder** does not promptly report to **us** the names of any persons who are added or deleted from

the eligible class(es);

8. **we** determine that there is a significant change, in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the **Policyholder** and/or its persons; or
9. the **Policyholder** fails to pay any portion of the premium within the 31 day **grace period**.

We reserve the right to review and terminate all class(es) covered under the policy if any class(es) cease(s) to be covered.

If **we** amend or cancel this policy for reasons other than the **Policyholder's** failure to pay premiums, written notice will be mailed to the **Policyholder** at least 31 days prior to the amendment date or cancellation date. The **Policyholder** may cancel this policy if the amendments are unacceptable.

If any portion of the premium is not paid during the **grace period**, the policy will terminate automatically at the end of the **grace period**. The **Policyholder** is liable for premium for coverage during the **grace period**. The **Policyholder** must pay **us** all premium due for the full period the policy is in force.

The **Policyholder** may cancel this policy by written notice delivered to **us** at least 31 days prior to the cancellation date. When both the **Policyholder** and **we** agree, this policy can be canceled on an earlier date. If the **Policyholder** or **we** cancel this policy, coverage will end at 12:00 midnight Standard Time at the **Policyholder's** address on the last day of coverage.

If this policy is canceled, the cancellation will not affect a **payable claim**.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDED:

NAME	**LOCATION (CITY AND STATE)**
None	

120 Royall Street, Canton, Massachusetts 02021

GROUP LONG TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

GROUP POLICYHOLDER:	**TOWN OF WAYLAND**
GROUP POLICYHOLDER EFFECTIVE DATE:	**NOVEMBER 1, 2018**
GROUP POLICY NUMBER:	**G-54784-00001**
CERTIFICATE NUMBER:	**AS ON FILE WITH THE POLICYHOLDER**
INSURED:	**CLASS 01 EMPLOYEE OF TOWN OF WAYLAND**
INSURED EFFECTIVE DATE:	**AS ON FILE WITH THE POLICYHOLDER**
GOVERNING JURISDICTION:	**COMMONWEALTH OF MASSACHUSETTS**

Boston Mutual Life Insurance Company (referred to as We, Our, Us) welcomes **you** as a certificateholder.

This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

We have written **your** Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance **law**. If **you** have any questions about any of the terms and provisions, please consult **our** claims paying office. **We** will assist **you** in any way to help **you** understand **your** benefits.

If the terms and provisions of the Certificate of Coverage (issued to **you**) are different from the policy (issued to the **Policyholder**), the policy will govern. **Your** coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, **we** have discretionary authority within the reasonable limits established by the law to determine **your** eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. Standard Time at the **Policyholder's** address and end at 12:00 midnight Standard Time at the **Policyholder's** address.

Signed for Boston Mutual Life Insurance Company at its home office in Canton on the Policy Effective Date.

John Rubén Flores — Secretary

Paul A. Lunardo Jr — President

The policy covers disabilities due to an occupational sickness or injury.

The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

120 Royall Street, Canton, Massachusetts 02021

GROUP LONG TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF COVERAGE

GROUP POLICYHOLDER:	**TOWN OF WAYLAND**
GROUP POLICYHOLDER EFFECTIVE DATE:	**NOVEMBER 1, 2018**
GROUP POLICY NUMBER:	**G-54784-00002**
CERTIFICATE NUMBER:	**AS ON FILE WITH THE POLICYHOLDER**
INSURED:	**CLASS 01 EMPLOYEE OF TOWN OF WAYLAND**
INSURED EFFECTIVE DATE:	**AS ON FILE WITH THE POLICYHOLDER**
GOVERNING JURISDICTION:	**COMMONWEALTH OF MASSACHUSETTS**

Boston Mutual Life Insurance Company (referred to as We, Our, Us) welcomes **you** as a certificateholder.

This is your Certificate of Coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

We have written **your** Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance **law**. If **you** have any questions about any of the terms and provisions, please consult **our** claims paying office. **We** will assist **you** in any way to help **you** understand **your** benefits.

If the terms and provisions of the Certificate of Coverage (issued to **you**) are different from the policy (issued to the **Policyholder**), the policy will govern. **Your** coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the **laws** of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, **we** have discretionary authority within the reasonable limits established by the law to determine **your** eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. Standard Time at the **Policyholder's** address and end at 12:00 midnight Standard Time at the **Policyholder's** address.

Signed for Boston Mutual Life Insurance Company at its home office in Canton on the Policy Effective Date.

John Rubén Flores — Secretary

Val A. Romano Jr. — President

The policy covers disabilities due to an occupational sickness or injury.

The policy does not replace or affect the requirements for coverage by any Workers' Compensation or state disability insurance.

CERTIFICATE OF COVERAGE
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BENEFITS AT A GLANCE

LONG TERM DISABILITY

The Long Term Disability policy provides financial protection for **you** by paying a portion of **your** income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before **your** disability began, subject to all policy provisions.

NAME OF EMPLOYER: TOWN OF WAYLAND

POLICY NUMBER: G-54784-00001

ELIGIBLE CLASS(ES): CLASS 01

All Full Time Active Employees Electing Option 1 in **active employment** in the United States with the **Employer**.

You must be an **employee** of the **Employer** and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT:

20 hours per week

WAITING PERIOD:

For persons in an eligible class on or before the policy effective date: None

For persons entering an eligible class after the policy effective date: 1st of the month following 30 days

REHIRE:

If **your** employment ends and **you** are rehired within 12 months **your** previous work while in an eligible class, will apply toward the **waiting period**. All other policy provisions apply.

WAIVE THE WAITING PERIOD:

If **you** have been continuously employed by **your Employer** for a period of time equal to **your waiting period**, **we** will waive **your waiting period** when **you** enter an eligible class.

WHO PAYS FOR THE COVERAGE:

You pay the cost of **your** coverage.

WAIVER OF PREMIUM:

We do not require premium payments for **your** coverage while **you** are receiving or are entitled to receive Long Term Disability payments under the policy.

ELIMINATION PERIOD:

The latest of:
1. 90 consecutive days for disability due to **injury**;
2. 90 consecutive days for disability due to a **sickness**; or

the date **your salary continuation** or **accumulated sick leave** or short term disability payments end, if applicable.

The elimination period begins on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

MONTHLY BENEFIT:

At least $300 per month, elected in $100 increments, not to exceed 60% of **your monthly earnings** up to a **maximum benefit** of $6,000.

Your benefit may be reduced by any **deductible sources of income** and **disability earnings**. Some disabilities may not be covered or may have limited coverage under the policy.

SECTION 1
BENEFITS AT A GLANCE

LONG TERM DISABILITY

The Long Term Disability policy provides financial protection for **you** by paying a portion of **your** income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before **your** disability began, subject to all policy provisions.

NAME OF EMPLOYER: TOWN OF WAYLAND

POLICY NUMBER: G-54784-00002

ELIGIBLE CLASS(ES): CLASS 01

All Full Time Active Employees Electing Option 2 in **active employment** in the United States with the **Employer**.

You must be an **employee** of the **Employer** and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT:

20 hours per week

WAITING PERIOD:

For persons in an eligible class on or before the policy effective date: None

For persons entering an eligible class after the policy effective date: 1st of the month following 30 days

REHIRE:

If **your** employment ends and **you** are rehired within 12 months **your** previous work while in an eligible class, will apply toward the **waiting period**. All other policy provisions apply.

WAIVE THE WAITING PERIOD:

If **you** have been continuously employed by **your Employer** for a period of time equal to **your waiting period**, **we** will waive **your waiting period** when **you** enter an eligible class.

WHO PAYS FOR THE COVERAGE:

You pay the cost of **your** coverage.

WAIVER OF PREMIUM:

We do not require premium payments for **your** coverage while **you** are receiving or are entitled to receive Long Term Disability payments under the policy.

ELIMINATION PERIOD:

The latest of:
1. 180 consecutive days for disability due to **injury**;
2. 180 consecutive days for disability due to a **sickness**; or

the date **your salary continuation** or **accumulated sick leave** or short term disability payments end, if applicable.

The elimination period begins on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

MONTHLY BENEFIT:

At least $300 per month, elected in $100 increments, not to exceed 60% of **your monthly earnings** up to a **maximum benefit** of $6,000.

Your benefit may be reduced by any **deductible sources of income** and **disability earnings**. Some disabilities may not be covered or may have limited coverage under the policy.

MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY:

$6,000 per month

MONTHLY EARNINGS:

"**Monthly Earnings**" means **your** gross monthly income from **your Employer** in effect just prior to **your** date of disability. It includes **your** total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than **your Employer**.

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the **monthly payment**.

MAXIMUM PERIOD OF PAYMENT:

Age When Disability Begins	**Maximum Period of Payment**
Less than age 60	To age 65 but not less than 5 years
Age 60 - 64	5 years
Age 65 - 69	To age 70, but not less than 1 year
Age 70 and over	1 year

REGULAR OCCUPATION PERIOD:

24 Months

TOTAL BENEFIT CAP:

If **you** are eligible to receive payments under the policy in addition to **your monthly payment**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings**.

The above items are only highlights of the policy. For a full description of your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading your Certificate of Coverage.

SECTION 2
DEFINITIONS

ACCIDENT OR ACCIDENTAL *means a sudden, unexpected event that was not reasonably foreseeable.*

ACTIVE EMPLOYMENT *means* ***you*** *are working for* ***your Employer*** *for earnings that are paid regularly and that* ***you*** *are performing the* ***material and substantial duties*** *of* ***your regular occupation****.* ***You*** *must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT in the BENEFITS AT A GLANCE.*

To be in ***active employment****,* ***your*** *work site must be:*
your Employer's *usual place of business; or*

1. *an alternative work site at the direction of* ***your Employer****, including* ***your*** *home; or*
2. *a location to which* ***your*** *job requires* ***you*** *to travel.*

Normal vacation is considered ***active employment****.*
Temporary and seasonal workers are excluded from coverage.

APPROPRIATE CARE *means that* ***you****:*

1. *regularly visit a* ***doctor*** *as frequently as medically required according to standard medical practice to effectively treat and manage* ***your*** *disabling condition(s); and*
2. *receive care or treatment appropriate for the disabling condition(s), conforming with standard medical practice, by a* ***doctor*** *whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and*
3. *have the obligation to minimize* ***your*** *disabling condition including having corrective treatment or minor surgery.*

CONTEST *means that, if* ***we*** *determine* ***you*** *made a material misrepresentation in* ***your*** *application for coverage under the policy,* ***we*** *assert in writing that such coverage was therefore never effective. The contest is effective on the date* ***we*** *mail the letter along with a refund of premium.*

DEDUCTIBLE SOURCES OF INCOME *means income from other sources as listed in the policy which* ***you*** *receive or are eligible to receive while* ***you*** *are disabled. This income will be subtracted from* ***your gross monthly payment****.*

DISABILITY EARNINGS *means the earnings which* ***you*** *receive while* ***you*** *are disabled and working, plus the earnings* ***you*** *could receive if* ***you*** *were working to* ***your maximum capacity****.*

DOCTOR *means:*

1. *a person performing tasks that are within the limits of his or her medical license; and*
2. *a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or*
3. *a person with a doctoral degree in Psychology (Ph. D. or Psy. D.) whose primary practice is treating patients; or*
4. *a person who is a legally qualified medical practitioner according to the* ***laws*** *and regulations of the governing jurisdiction.*

We *will not recognize* ***you*** *or* ***your*** *family members, including but not limited to, spouse, domestic partner, children, parents, including in-laws, or siblings, including in-laws, a business or professional partner, or any person who has a financial affiliation or business interest with* ***you*** *as* ***a doctor*** *for a claim that* ***you*** *send to* ***us****.*

ELIGIBLE SURVIVOR *means* ***your*** *spouse, if living; otherwise,* ***your*** *children under age 26.*

EMPLOYEE *means a person who is a citizen or legal resident of the United States in* ***active employment*** *with the* ***Employer*** *in the United States.*

EMPLOYER *means the* ***Policyholder*** *and includes any division, subsidiary, or affiliated company named in the policy.*

ENROLL *means* ***you*** *have completed the process of applying for coverage under the policy.*

ENROLLMENT FORM *means the application* ***you*** *complete and submit to* ***us*** *to apply for coverage under the policy.*

EVIDENCE OF INSURABILITY *means a statement of* ***your*** *medical history that* ***we*** *will use to determine if* ***you*** *are approved for coverage.* ***Evidence of insurability*** *will be provided at* ***your*** *own expense.*

EVIDENCE OF INSURABILITY FORM *means the portion of the* ***enrollment form*** *that* ***you*** *complete and submit to* ***us*** *that contains a statement of* ***your*** *medical history.*

GAINFUL OCCUPATION *means an occupation that is or can be expected to provide* ***you*** *with an income within 12 months of* ***your*** *return to work, that exceeds:*

80% of ***your indexed monthly earnings****, if* ***you*** *are working;*
60% of ***your indexed monthly earnings****, if* ***you*** *are not working.*

GRACE PERIOD *means the 31 day period following the premium due date during which premium payment for the policy may be made by the* ***Policyholder.***

GROSS MONTHLY PAYMENT *means* ***your*** *benefit before any reduction for* ***deductible sources of income*** *[and* ***disability earnings****.*

HOSPITAL, HEALTH FACILITY OR INSTITUTION *means an accredited facility licensed to provide care and treatment for the condition causing* ***your*** *disability.*

INDEXED MONTHLY EARNINGS *means* ***your monthly earnings*** *adjusted on each anniversary of benefit payment by the lesser of 10% or the current annual percentage increase in the Consumer Price Index.* ***Your indexed monthly earnings*** *may increase or remain the same, but will never decrease.*

The Consumer Price Index CPI-U is published by the U.S. Department of Labor. ***We*** *reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while* ***you*** *are disabled and working and in the determination of* ***gainful occupation****.*

INJURY *means a bodily* ***injury*** *that is the direct result of an* ***accident*** *and not related to any other cause. The* ***injury*** *must occur, and disability resulting from the* ***injury*** *must begin while* ***you*** *are covered under the policy.* ***Injury*** *that occurs before* ***you*** *are covered under the policy will be treated as a* ***sickness****.*

INSURED *means any person covered under the policy.*

INSURED PERSON *means a person who is eligible for the coverage under this policy, becomes covered according to the terms of the policy, and whose coverage remains in effect according to the terms of the policy.*

LAW*,* ***PLAN****, or* ***ACT*** *means the original enactments of the law, plan, or act and all amendments.*

LEAVE OF ABSENCE *means* ***you*** *are absent from* ***active employment*** *for a period of time that has been agreed to in advance in writing by* ***your Employer****.*

Your *normal vacation time or any period of disability is not considered a* ***temporary layoff*** *or* ***leave of absence****.*

MATERIAL AND SUBSTANTIAL DUTIES *means duties that:*

1. *are normally required for the performance of* ***your regular occupation****; and*
2. *cannot be reasonably omitted or modified, except that if* ***you*** *are required to work on average in excess of 40 hours per week,* ***we*** *will consider* ***you*** *able to perform that requirement if* ***you*** *have the capacity to work 40 hours per week.*

MAXIMUM BENEFIT *means the total monthly benefit amount for which* ***you*** *are insured under the policy subject to all policy provisions.*

MAXIMUM CAPACITY *means, based on* ***your*** *restrictions and limitations:*

1. *during the* ***regular occupation period****, the greatest extent of work* ***you*** *are able to do in* ***your regular occupation****; and*
2. *beyond the* ***regular occupation period****, the greatest extent of work* ***you*** *are able to do in any occupation for which* ***you*** *are reasonably fitted by education, training or experience.*

MAXIMUM PERIOD OF PAYMENT means the longest period of time** we **will make payments to** you **for any one period of disability.

***MENTAL ILLNESS** means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders related to stress or to substance abuse or dependency. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.*

***MONTHLY EARNINGS** means **your** gross monthly income from **your Employer** as stated in the BENEFITS AT A GLANCE.*

***MONTHLY PAYMENT** means **your** benefit after any **deductible sources of income** and **disability earnings** have been subtracted from **your gross monthly payment**.*

***OCCUPATIONAL SICKNESS OR INJURY** means a **sickness** or **injury** that was caused by or aggravated by any employment for pay or profit.*

***PART- TIME BASIS** means the ability to work and earn from 20% through 80% of **your indexed monthly earnings**. Ability is based on capacity and not market availability.*

***PAYABLE CLAIM** means a claim for which **we** are liable under the terms of the policy.*

***POLICYHOLDER** means the **Employer** to whom the policy is issued and who sponsored the coverage for its **employees**.*

***PRE-EXISTING CONDITION** means any condition for which **you** have done any of the following at any time during the 3 months just prior to **your** effective date of coverage, whether or not that condition is diagnosed at all or is misdiagnosed:*

1. *received medical treatment or consultation;*
2. *taken or were prescribed drugs or medicine; or*
3. *received care or services, including diagnostic measures.*

***RECURRENT DISABILITY** means a disability which is:*

1. *caused by a worsening in **your** condition; and*
2. *due to the same cause(s) as **your** prior disability for which **we** made a **monthly payment**.*

***REGULAR OCCUPATION** means the occupation **you** are routinely performing when **your** disability begins. **We** will look at **your** occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.*

***REGULAR OCCUPATION PERIOD** is the period of time shown in the BENEFITS AT A GLANCE that begins after the elimination period.*

***RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to **employees** and are not funded entirely by **employee** contributions. **Retirement plan** includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.*

***SALARY CONTINUATION** or **ACCUMULATED SICK LEAVE** means continued payments to **you** by **your Employer** of all or part of **your monthly earnings**, after **you** become disabled as defined by the policy. This continued payment must be part of an established plan maintained by **your Employer**, and includes **salary continuation**, **accumulated sick leave** or any similar **Employer** sponsored paid time off plan.*

***SICKNESS** means illness, disease or physical condition. Disability resulting from the **sickness** must begin while **you** are covered under the policy.*

***VOCATIONAL REHABILITATION PLAN** means a written plan that a vocational rehabilitation professional, designated by **us**, prepares in accordance with the VOCATIONAL REHABILITATION SERVICES provision of the policy.*

***WAITING PERIOD** means the continuous period of time (shown in the BENEFITS AT A GLANCE) that **you** must be in **active employment** in an eligible class before **you** are eligible for coverage under the policy.*

WE, ***US***, *and* ***OUR*** *means Boston Mutual Life Insurance Company.*

YOU *and* ***YOUR*** *means a person who is eligible for coverage under the policy.*

SECTION 3
GENERAL PROVISIONS

CERTIFICATE OF COVERAGE

This Certificate of Coverage is a written statement prepared by **us** and may include attachments. It tells **you**:

1. the coverage to which **you** may be entitled;
2. to whom **we** will make a payment; and
3. the limitations, exclusions and requirements that apply within the policy.

ELIGIBILITY DATE

If **you** are working for **your Employer** in an eligible class, the date **you** are eligible for coverage is the later of:

1. the policy effective date; or
2. the day after **you** complete **your waiting period**.

WHEN COVERAGE BEGINS

When **your Employer** pays 100% of the cost of **your** coverage under the policy, **you** will be covered at 12:01 a.m. Standard Time at **your Employer's** address on the date **you** are eligible for coverage.

When **you** and **your Employer** share the cost of **your** coverage under the policy or when **you** pay 100% of the cost yourself, **you** will be covered at 12:01 a.m. Standard Time at the **Policyholder's** address on the latest of:

1. the date **you** are eligible for coverage, if **you enroll** for insurance on or before that date;
2. the date **you enroll** for insurance, if **you enroll** within 31 days after the date **you** become eligible for coverage; or
3. the date **we** approve **your enrollment form**, if **evidence of insurability** is required.

In order for **your** coverage to begin, **you** must be in **active employment**. **Your** coverage is subject to payment of premium.

CHANGES TO YOUR COVERAGE

Once **your** coverage begins, any increased or additional coverage will take effect immediately if **you** are in **active employment** or if **you** are on a covered **leave of absence**. If **you** are not in **active employment** due to **injury** or **sickness**, any increased or additional coverage will begin on the date **you** return to **active employment**.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of Insurability is required if:

1. **you** are a late applicant, which means **you** apply for coverage more than 31 days after the date **you** are eligible for coverage;
2. **you** voluntarily canceled **your** coverage and are reapplying;
3. **you** apply for a monthly benefit amount greater that the MAXIMUM BENEFIT AMOUNT WITHOUT EVIDENCE OF INSURABILITY as shown in the BENEFITS AT A GLANCE, when **you** first become eligible for coverage under the policy;
4. **you** apply to increase **your** monthly benefit by any amount during the policy year; or
5. **you** apply to increase **your** monthly benefit by more than $100 during an annual enrollment period.

An **evidence of insurability form** can be obtained from **your Employer**.

IF YOU ARE ON A LEAVE OF ABSENCE AFTER YOUR COVERAGE BEGINS

If **you** are on a **leave of absence**, and if premium is paid, **your** coverage may be continued beyond the date **you** are no longer in **active employment**, limited to the time periods described below.

If **you** are on a **leave of absence** as described under the Family and Medical Leave **Act** of 1993 ("FMLA") or applicable state family and medical leave **law** ("State FML"), and **your Employer's** Human Resource Policy provides for continuation of

disability coverage during an FMLA or State FML **leave of absence**, **your** coverage will be continued until the end of the later of:

1. the leave period permitted by the federal Family and Medical Leave **Act** of 1993 and any amendments; or
2. the leave period permitted by applicable state **law**.

If **you** are on a **leave of absence** other than an FMLA or State FML **leave of absence**, and if premium is paid, **your** coverage will be continued through the end of the month that immediately follows the month in which **your leave of absence** begins.

If **you** are on a **leave of absence** for active military service as described under the Uniformed Services Employment and Reemployment Rights **Act** of 1994 (USERRA) and applicable state **law**, **your** coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate of Coverage for an FMLA or State FML **leave of absence**; or
2. the length of time the coverage may be continued under the Certificate of Coverage for a **leave of absence** other than an FMLA or State FML **leave of absence**.

If **your Employer** has approved more than one type of **leave of absence** for **you** during any one period that **you** are not in **active employment**, **we** will consider such leaves to be concurrent for the purpose of determining how long **your** coverage may continue under the policy.

If **your** coverage is not continued during an FMLA or State FML **leave of absence**, and **you** return to **active employment** immediately following the end of **your** FMLA or State FML **leave of absence**, **your** coverage will be reinstated. **We** will not apply a new **waiting period**, require **evidence of insurability**, or apply a new **pre-existing condition** limitation.

If **your** coverage is not continued during a **leave of absence** for active military service, and **you** return to **active employment**, **your** coverage may be reinstated in accordance with USERRA and applicable state **law**.

In no event will **your** coverage under the policy be continued beyond the date **your** coverage would otherwise end according to the terms of the WHEN YOUR COVERAGE ENDS provision.

WHEN YOUR COVERAGE ENDS

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled;
2. the date **you** are no longer in an eligible class;
3. the date **your** eligible class is no longer covered;
4. the end of the period for which **you** paid premiums, if **you** stop making a required premium contribution;
5. the end of the **Policyholder's grace period** if the **Policyholder** does not remit premium to **us** by the end of such period; or
6. the last day **you** are in **active employment** except as provided under a covered **leave of absence**.

We will provide coverage for a **payable claim** that occurs while **you** are covered under the policy.

TIME LIMITS FOR LEGAL PROCEEDINGS

You can start legal action regarding **your** claim 60 days after proof of claim has been given to **us**, and up to three years from the time proof of claim is required, unless otherwise provided under federal **law**.

STATEMENTS MADE IN AN APPLICATION FOR COVERAGE

We consider any statements **you** or **your Employer** make in an application representations and not warranties. No statements made by **you** will be used to reduce or deny any claim or to cancel **your** coverage unless:

1. the statement is in writing and is signed by **you**; and
2. a copy of that statement is given to **you** or **your** beneficiary.

TIME LIMIT ON CERTAIN DEFENSES

Except in the case of fraud, no statement made by **you** relating to **your** insurability will be used to **contest** the insurance for which the statement was made after the coverage has been in force for two years.

Beyond the periods stated in the PRE-EXISTING CONDITION LIMITATION provision, no claim for disability with respect to which the claim is made, shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of disability, had existed prior to the effective date of the coverage.

CLERICAL ERROR

Clerical error or omission by **us** or **your Employer** will not:

1. prevent **you** from receiving coverage, if **you** are entitled to coverage under the terms of the policy; or
2. cause coverage to begin or continue for **you** when the coverage would not otherwise be effective.

If the **Employer** gives **us** information about **you** that is incorrect, **we** will:

1. use the facts to decide whether **you** have coverage under the policy and in what amounts; and
2. only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

MISSTATEMENT OF AGE

If premiums applicable to **you** are based on age and **you** have misstated **your** age, there will be a fair adjustment of premiums based on **your** true age. If the benefits applicable to **you** are based on age and **you** have misstated **your** age, there will be an adjustment of said benefits based on **your** true age. **We** may require satisfactory proof of **your** age before paying any claim.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy, the **Employer** acts on its own behalf or as **your** agent. Under no circumstances will the **Employer** be deemed **our** agent.

SECTION 4
LONG TERM DISABILITY
BENEFIT INFORMATION

DEFINITION OF DISABILITY

You are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**:

1. **you** are unable to perform all the **material and substantial duties** of **your regular occupation**; and
2. **you** have a 20% or more loss in **your indexed monthly earnings**.

After the **regular occupation period**, **you** are considered disabled when **we** review **your** claim and determine that, due to **your sickness** or **injury**, **you** are unable to perform the duties of any **gainful occupation** for which **you** are reasonably qualified based on **your** training, education and experience.

The loss of a professional or an occupational license or certification does not, in itself, constitute disability.

You must be under the **appropriate care** of a **doctor** in order to be considered disabled.

We may require **you** to be examined by one or more **doctors**, other medical practitioners, or vocational experts of **our** choice. **We** will pay for this examination. **We** can require an examination as often as it is reasonable to do so. **We** may also require **you** to be interviewed by **our** authorized representative. **Your** failure to comply with this request may result in denial or termination of benefits.

ELIMINATION PERIOD

You must be continuously disabled through **your** elimination period. **Your** elimination period is as stated in the BENEFITS AT A GLANCE and is the period of continuous disability **you** must satisfy before **you** are eligible to receive benefits under the policy.

For an elimination period more than 90 days, **we** will consider **your** disability as continuous if **your** disability stops during the elimination period for 30 days or less.

For an elimination period of 90 days, **we** will consider **your** disability as continuous if **your** disability stops during the elimination period for 14 days or less.

For an elimination period of 31 to 90 days, **we** will consider **your** disability as continuous if **your** disability stops during the elimination period for 7 days or less for each 30 days of elimination period.

If **your** elimination period is less than 31 days, and **your** disability stops during the elimination period, **we** will not consider **your** disability to be continuous.

The days that **you** are not disabled will not count toward **your** elimination period.

The elimination period begins on the first day of **your** disability.

Benefits for a **payable claim** begin the day after the elimination period is completed.

SATISFYING YOUR ELIMINATION PERIOD IF YOU ARE WORKING

If **you** are working while **you** are disabled, the days **you** are disabled will count toward **your** elimination period.

WHEN YOU RECEIVE PAYMENTS

You will begin to receive payments when **we** approve **your** claim, providing the elimination period has been met and **you** are disabled. **We** will send **you** a **monthly payment** at the end of each month for any period for which **we** are liable.

After the elimination period, if **you** are disabled for less than 1 month, **we** will send **you** 1/30th of **your monthly payment** for each day of **your** disability.

AMOUNT OF PAYMENT

A. IF YOU ARE DISABLED AND NOT WORKING, OR DISABLED AND WORKING AND YOUR DISABILITY EARNINGS ARE LESS THAN 20% OF YOUR INDEXED MONTHLY EARNINGS

We will follow this process to figure **your** payment:

Your monthly payment will be the monthly benefit amount you elected and for which premium is being paid, not to exceed 60% of **your monthly earnings** or the **maximum benefit**, minus **deductible sources of income**.

B. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE AT LEAST 20% BUT LESS THAN OR EQUAL TO 80% OF YOUR INDEXED MONTHLY EARNINGS

During the first 12 months of payments, the sum of **your gross monthly payment** plus **disability earnings** may be less than or equal to, but not more than, 100% of **your indexed monthly earnings**. If the sum exceeds 100% of **your indexed monthly earnings**, **we** will reduce **your** payment under the policy by the excess amount.

To determine whether the sum of **your gross monthly payment** plus **disability earnings** is less than or equal to or exceeds 100% of **your indexed monthly earnings**, **we** will follow this process:

Add **your disability earnings** to **your gross monthly payment**. If the answer is less than or equal to 100% of **your indexed monthly earnings**, **your monthly payment** will be **your gross monthly payment** minus any **deductible sources of income**.
If the answer is less than or equal to 100% of **your indexed monthly earnings**, **your monthly payment** will be **your gross monthly payment** minus any **deductible sources of income**.

If the answer is greater than 100% of **your indexed monthly earnings**, **we** will follow this process to figure **your monthly payment**:

a. Add **your disability earnings** to **your gross monthly payment**.
b. From the answer in Item a, subtract **your indexed monthly earnings**. If the result is zero or less, record **your** answer as zero.
c. From **your gross monthly payment**, subtract the answer in Item b and any **deductible sources of income**.

The amount figured in Item c is **your monthly payment**.

After 12 months of **monthly payments**, **you** will receive payments based on the percentage of income **you** are losing due to **your disability**. **We** will follow this process to determine **your monthly payment**:

1. Subtract **your disability earnings** from **your indexed monthly earnings**.
2. Divide the answer in Item 1 by **your indexed monthly earnings**. The result is **your** percentage of lost earnings.
3. From **your gross monthly payment**, subtract any **deductible sources of income**.
4. Multiply the answer in Item 2 by the answer in Item 3.

The answer in Item 4 is **your monthly payment**.

C. IF YOU ARE DISABLED AND WORKING, AND YOUR DISABILITY EARNINGS ARE MORE THAN 80% OF YOUR INDEXED MONTHLY EARNINGS

If **you** are working and **your disability earnings** are more than 80% of **your indexed monthly earnings**, no benefit will be payable.

We may require **you** to send proof of **your** monthly **disability earnings** each month. **We** will adjust **your** payment based on **your** monthly **disability earnings**.

As part of **your** proof of **disability earnings**, **we** can require that **you** send **us** appropriate financial records that **we** believe are necessary to substantiate **your** income.

After the elimination period, if **you** are disabled for less than 1 month, **we** will send **you** 1/30th of **your monthly payment** for each day of disability.

IF YOUR DISABILITY EARNINGS FLUCTUATE

If **your disability earnings** routinely fluctuate widely from month to month, **we** may average **your disability earnings** over the most recent three months to determine if **your** claim should continue.

If **we** average **your disability earnings**, **we** will not terminate **your** claim unless the average of **your disability earnings** from the last three months exceeds 80% of **your indexed monthly earnings**.

We will not pay **you** for any month during which **your disability earnings** exceed the amount allowable under the policy. In no event will benefits be paid beyond the **maximum period of payment**.

WE WILL NEVER PAY MORE THAN 100% OF MONTHLY EARNINGS

If **you** are eligible to receive benefits under the policy in addition to the **monthly payment**, the total benefit payable to **you** on a monthly basis (including all benefits provided under the policy) will not exceed 100% of **your monthly earnings**.

DEDUCTIBLE SOURCES OF INCOME

The following are **deductible sources of income**:

1. The amount that **you** receive, or are eligible to receive, as disability income payments under any:

    a. state compulsory benefit **act** or **law**;
    b. individual disability income **plans** which are paid for by the **Policyholder** and purchased on or after the effective date of this policy;
    c. automobile liability insurance policy or "no fault" motor vehicle plan, whichever is applicable;
    d. military disability benefit plan;
    e. governmental retirement system as a result of **your** job with **your Employer**; or
    f. other group insurance policy.

2. The amount **you** receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).

3. The amount **you** receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

4. The amount that **you**:

    a. receive as disability payments under **your Employer's retirement plan**;
    b. voluntarily elect to receive as retirement payments under **your Employer's retirement plan**; or
    c. are eligible to receive as retirement payments when **you** reach the later of age 62 or normal retirement age, as defined in **your Employer's retirement plan**.

    Disability payments under a **retirement plan** will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

    Retirement payments will be those benefits which are paid based on **your Employer's** contribution to the **retirement plan**. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

    Regardless of how the retirement funds from the **retirement plan** are distributed, **we** will consider the **Employer** and **employee** contributions to be distributed simultaneously throughout **your** lifetime.

    Amounts received do not include amounts rolled over or transferred to any eligible **retirement plan**. **We** will use the definition of eligible **retirement plan** as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

5. The amount that **you**, **your** spouse, and **your** children receive, or are eligible to receive, as disability payments because of **your** disability under:

    a. the United States Social Security **Act**;
    b. the Canada Pension **Plan**;
    c. the Quebec Pension **Plan**; or
    d. any similar **Plan** or **Act**.

6. The amount that **you** receive as retirement payments or the amount **your** spouse and **your** children receive as retirement payments because **you** are receiving retirement payments under:

    a. the United States Social Security **Act**;
    b. the Canada Pension **Plan**;
    c. the Quebec Pension **Plan**; or
    d. any similar **Plan** or **Act**.

7. The amount **you** earn or receive from any form of employment.

8. The amount **you** receive from any unemployment compensation **law**.

9. The amount that **you** receive, or are eligible to receive, under:
    a. a workers' compensation **law**;
    b. an occupational disease **law**; or
    c. any other **act** or **law** with similar intent.

With the exception of retirement payments, **we** will only subtract **deductible sources of income** which are payable as a result of the same disability.

We will not reduce **your** payment by **your** Social Security retirement income if **your** disability begins after age 65 and **you** were already receiving Social Security retirement payments.

IF YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME

Other than for increases in any income **you** earn from any form of employment, once **we** have subtracted any **deductible source of income** from **your gross monthly payment**, **we** will not further reduce **your** payment due to a cost of living increase from that source.

IF YOU QUALIFY FOR DEDUCTIBLE SOURCES OF INCOME

When **we** determine that **you** may qualify for benefits for which **you** are eligible in the **deductible sources of income** section, **we** will estimate **your** entitlement to these benefits. **We** can reduce **your** benefit under the policy by the estimated amounts if such benefits:

1. have not been awarded or denied; or
2. have been denied and the denial is being appealed.

Your gross monthly payment will NOT be reduced by the estimated amount if **you**:

1. apply for the disability payments for which **you** are eligible in the **deductible sources of income** section and appeal **your** denial to all administrative levels **we** determine are necessary; and
2. sign **our** form. This form states that **you** promise to pay **us** any overpayment caused by an award and **we** shall be entitled to impose a constructive trust on any such award.

If **your gross monthly payment** has been reduced by an estimated amount, **your gross monthly payment** will be adjusted when **we** receive proof:

1. of the amount awarded; or
2. that benefits have been denied and all appeals **we** determine are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to **you**.

If **you** receive a lump sum payment from any **deductible source of income**, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis from the date of the award over **your** expected lifetime as determined by **us**.

NON-DEDUCTIBLE SOURCES OF INCOME

We will not subtract from **your gross monthly payment** income **you** receive from, the following:

1. 401(k) plans;
2. **salary continuation** or **accumulated sick leave** plans;
3. profit sharing plans;
4. thrift plans;
5. tax-sheltered annuities;
6. stock ownership plans;
7. credit disability insurance;
8. non-qualified plans of deferred compensation;
9. pension plans for partners;
10. military pension plans;
11. franchise disability income plans;
12. individual disability plans paid for by the **insured person**;
13. a retirement plan from another employer;
14. individual retirement accounts (IRA).

If **salary continuation** or **accumulated sick leave** plan payments plus the **gross monthly payment** and **disability earnings** exceed 100% of **your monthly earnings**, **we** will subtract the amount in excess of 100% from **your monthly payment**.

MINIMUM PAYMENT

The minimum payment each month for a **payable claim** is the greater of:

1. $100; or
2. 10% of **your gross monthly payment**.

We may apply this amount to recover an outstanding overpayment.

DURATION OF PAYMENTS

We will send **you** a payment each month up to the **maximum period of payment**. **Your maximum period of payment** is stated in the BENEFITS AT A GLANCE, will be paid during a continuous period of disability, and will be based on **your** age at disability.

WHEN PAYMENTS END

We will stop sending **you** payments and **your** claim will end on the earliest of the following:

1. the end of the **maximum period of payment**;
2. the date **you** are no longer disabled under the terms of the policy;
3. the date **you** fail to submit proof of continuing disability;
4. the date **you** die;
5. during the **regular occupation period** when **you** are able to return to work in **your regular occupation** on a **part-time basis** but **you** do not;
6. after the **regular occupation period**, when **you** are able to work in any **gainful occupation** on a **part-time basis** but **you** do not;
7. the date **your disability earnings** exceed 80% of **your indexed monthly earnings**; or
8. after 12 months of payments if **you** are considered to reside outside the United States or Canada. **You** will be considered to reside outside these countries when **you** have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits.

We will not pay a benefit for any period of disability during which **you** are incarcerated.

DISABILITIES NOT COVERED UNDER THE POLICY

The policy does not cover any disabilities caused by, contributed to by, or resulting from **your**:

1. loss of professional license, occupational license, or certification;
2. participation in a felony;
3. intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. participation in a war, declared or undeclared, or any act of war;
6. active military duty;
7. active participation in a riot;
8. engaging in any illegal or fraudulent occupation, work, or employment;

9. commission of a crime for which **you** have been convicted;
10. elective surgery except when required for **your appropriate car**e as a result of **your injury** or **sickness**; or
11. traveling or flying on any aircraft operated by or under authority of military or any aircraft being used for experimental purposes.

The policy does not cover any disabilities resulting from **your** being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **doctor**.

PRE-EXISTING CONDITION LIMITATION

Benefits will not be paid if **your** disability begins in the first 12 months following the effective date of **your** coverage and **your** disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which:

1. **you** received medical treatment, consultation, care or services, including diagnostic measures, or took or were prescribed drugs or medicines in the 3 months just prior to **your** effective date of coverage.

MENTAL ILLNESS, ALCOHOLISM OR DRUG ABUSE LIMITATION

The lifetime cumulative **maximum period of payment** for all disabilities due to **mental illness**, alcoholism or drug abuse is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

1. are not continuous; and/or
2. are not related.

We will continue to send **you** payments beyond the 24 month period if **you** meet one or both of these conditions:

1. If **you** are confined to a **hospital**, **health facility or institution** at the end of the 24 month period, **we** will continue to send **you** payment(s) during **your** confinement.

   If **you** are still disabled when **you** are discharged, **we** will send **you** payment(s) for a recovery period of up to 90 days.

   If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, **we** will send payment(s) during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if **you** continue to be disabled after the 24 month period, and subsequently become confined to a **hospital**, **health facility or institution** for at least 14 days in a row, **we** will send payment(s) during the length of the reconfinement.

We will not make payments beyond the limited pay period as indicated above, or the **maximum period of payment**, whichever occurs first.

We will not apply the **mental illness** limitation to a disability due to dementia if it is a result of:

1. stroke;
2. trauma;
3. viral infection; or
4. Alzheimer's disease.

RECURRENT DISABILITY

If **you** have a **recurrent disability**, and after **your** prior disability ended, **you** returned to work for **your Employer** for 6 months or less, **we** will treat **your** disability as part of **your** prior claim and **you** do not have to complete another elimination period.

Your monthly payment will be based on **your monthly earnings** as of the date of **your** initial claim.

Your disability, as outlined above, will be subject to the same terms of this policy as **your** prior claim.

Your disability will be treated as a new claim if **your** current disability:
1. is unrelated to **your** prior disability; or
2. after **your** prior disability ended, **you** returned to work for **your Employer** for more than 6 consecutive months.

The new claim will be subject to all of the provisions of the policy and **you** will be required to satisfy a new elimination period.

If **our** policy terminates and **you** become eligible for payments under any other group disability plan that replaces **our** policy, **you** will not be eligible for payments under **our** policy.

BENEFITS IF YOU DIE - SURVIVOR BENEFIT

When **we** receive proof that **you** have died, **we** will pay **your eligible survivor** a lump sum benefit equal to three (3) times **your** last **monthly payment** if, on the date of **your** death:

1. **your** disability had continued for 180 or more consecutive days; and
2. **you** were receiving or were eligible to receive payments under the policy.

If **you** have no **eligible survivors**, payment will be made to **your** estate, unless there is none. In this case, no payment will be made.

However, **we** will first apply the Survivor Benefit to recover any overpayment that may exist on **your** claim.

IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER REPLACES INSURANCE COVERAGE WITH OUR POLICY

If **you** are not in **active employment** due to **injury**, **sickness**, or **leave of absence** on the date **your Employer** changes insurance carriers to **our** policy, and **you** were covered under the prior policy at the time **your Employer's** coverage under **our** policy became effective, **we** will provide continuity of coverage under **our** policy. In order for this provision to apply, the prior policy's coverage must be similar to **our** policy.

If **you** are not in **active employment** due to **injury**, **sickness**, or **leave of absence** on the effective date of **our** policy, and **you** would otherwise be eligible to become insured under **our** policy, **we** will provide limited coverage under **our** policy. Coverage under this provision will begin on **our** policy effective date and will continue until the earliest of:

1. the end of the month following the date **you** return to **active employment**; or
2. the end of any period of continuance or extension provided under the prior policy; or
3. the date coverage would otherwise end, according to the provisions of **our** policy.

Your coverage under this provision is subject to payment of premium.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. **We** will reduce **your** payment by any amount for which the prior carrier is liable.

If coverage ends under this provision, or if **you** were not covered under **your Employer's** prior policy on the date that policy terminated, the WHEN COVERAGE BEGINS provision under **our** policy will apply.

IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR INSURANCE COVERAGE IS REPLACED WITH COVERAGE UNDER OUR POLICY

We may send a payment if **your** disability is caused by, contributed by or results from a **pre-existing condition** if:

1. **you** were insured by the prior policy at the time **your** insurance coverage is replaced with coverage under **our** policy; and
2. **you** have been continuously covered under **our** policy from the date **you** were last insured by the prior policy through the date **your** disability began.

For the purpose of this section, insured by the prior policy means:

1. **you** were covered under a group policy through the **Employer** which has been replaced by **our** policy; or
2. **you** were covered by another group policy within 30 days of **your** effective date under **our** policy and **your** prior coverage has been replaced.

In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under:

1. **our** policy; or
2. the prior policy, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our** policy, **we** will determine **your** payments according to **our** policy's provisions.

If **you** do not satisfy the **pre-existing condition** provision of this policy, but y**ou** do satisfy the prior policy's **pre-existing condition** provision:

1. **your monthly payment** will be the lesser of:

    a. the **monthly payment** that would have been payable under the terms of the prior policy if it had remained in force; or
    b. the **monthly payment** under **our** policy; and

2. benefits will end on the earlier of:

    a. the date benefits end under **our** policy, as described under the DURATION OF PAYMENTS provision; or
    b. the date benefits would have ended under the prior policy if it had remained in force.

If **you** do not satisfy either **our** policy's or the prior policy's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of **our** policy will apply.

VOCATIONAL REHABILITATION SERVICES

We have vocational rehabilitation services available to assist **you** in returning to work to the extent of **your** ability. **We** will review **your** disability claim to determine whether **you** are eligible for these services, at **our** sole discretion. In order to be eligible for vocational rehabilitation services, **you** must be medically able to participate in a return to work plan.

Your claim file will be reviewed by a vocational rehabilitation professional to determine if rehabilitation services might help **you** return to gainful employment. As **your** file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work plan.

We will make the final determination of **your** eligibility for these services.

If **we** determine that vocational rehabilitation services are appropriate, **we** will provide **you** with a written **vocational rehabilitation plan** developed specifically for **you**.

The **vocational rehabilitation plan** may include at **our** sole discretion, but is not limited to, the following services:

1. coordination with **your Employer** to assist **you** to return to work;
2. evaluation of adaptive equipment or job accommodations to allow **you** to work;
3. evaluation of possible workplace modifications which might allow **you** to return to work in **your regular occupation** or another job or occupation;
4. vocational evaluation to determine how **your** disability may impact **your** employment options;
5. job placement services, including resume preparation services and training in job-seeking skills;
6. alternative treatment plans such as recommendations for support groups, physical therapy, occupational therapy, or other treatment designed to enhance **your** ability to work.

WORKPLACE MODIFICATION BENEFIT

If **you** are disabled and are receiving a payment from **us**, an additional Workplace Modification Benefit may be payable to **your Employer** for **your** benefit. **We** may reimburse **your Employer** for up to 100% of the reasonable costs **your Employer** incurs through modifications to the workplace to accommodate **your** return to work, and to assist **you** in remaining at work.

The amount **we** may pay will not exceed the lesser of:
1. two times **your** last **monthly payment**; or
2. $2,000.

To qualify for this reimbursement, **you** must:
1. be disabled according to the terms of the policy; and
2. have the reasonable expectation of returning to **active employment** and remaining in **active employment** with the assistance of the proposed workplace modification.

Your Employer must give **us** a written proposal of the proposed workplace modification. This proposal must include:

1. input from the **Employer**, **you** and **your doctor**;
2. the purpose of the proposed workplace modification;
3. the expected completion date of the workplace modification; and
4. the cost of the workplace modification.

We will reimburse the costs of the workplace modification when **we**:

1. approve the proposal in writing;
2. receive proof from **your Employer** that the workplace modification is complete; and
3. receive proof of the costs incurred by **your Employer** for the workplace modification.

This benefit is available on a one time basis.

CHILD CARE EXPENSE BENEFIT

If **you** are receiving **monthly payments** under the policy, and **you** are participating in a **vocational rehabilitation plan**, **you** will be eligible for an additional Child Care Expense Benefit if **you** are incurring expenses to provide care for a **child** under age 15 who requires personal care assistance.

We will pay a Child Care Expense Benefit of $350 per **child** not to exceed a maximum of $1,000 per month.

The Child Care Expense Benefit will end on the earliest of the following dates:

1. the date **you** are no longer incurring **child** care expenses;
2. the date **you** are no longer participating in a **vocational rehabilitation plan**;
3. after 12 months of Child Care Expense Benefits have been paid for each **child**; or
4. any other date on which **monthly payments** would stop in accordance with the policy.

To receive this benefit, **you** must provide satisfactory proof that **you** are incurring a **child** care expense.

Child care means care or supervision of **your child**; and care is given by a licensed child-care center or a licensed caregiver who is not related to **you** by blood or marriage.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as **deductible sources of income**. However, the Total Benefit Cap will apply.

SECTION 5
LONG TERM DISABILITY - CLAIM INFORMATION

NOTICE OF CLAIM

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be given to **us** within 30 days after the date **your** disability begins. The notice may be given to **us** at **our** home office or to **our** authorized agent. Failure to give notice within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

The claim form is available from **your Employer**, or **you** can request a claim form from **us**. If **you** do not receive the form from **us** within 15 days of **your** request, send **us** written proof of claim without waiting for the form.

You must notify **us** immediately when **you** return to work in any capacity.

FILING A CLAIM

You and **your Employer** must fill out **your** own sections of the claim form and then give it to **your** attending **doctor**. **Your doctor** should fill out his or her section of the form and send it directly to **us**.

PROOF OF YOUR CLAIM

You must send **us** written proof of **your** claim no later than 90 days after **your** elimination period. Failure to give such proof within this timeframe shall not invalidate or reduce any **payable claim** if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. **You** must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Your proof of claim, provided at **your** expense, must show:
1. that **you** are under the **appropriate care** of a **doctor**;
2. the date **your** disability began;
3. the cause of **your** disability;
4. the appropriate documentation of **your** earnings and **your** activities;
5. the extent of **your** disability, including restrictions and limitations preventing **you** from performing **your regular occupation**;
6. the name and address of any **hospital**, **health facility** or **institution** where **you** received treatment, including all attending **doctors**; and
7. documentation of prior disability coverage, if applicable.

In some cases, **you** will be required to give **us** authorization to obtain additional medical information, and to provide non-medical information as part of **your** proof of claim, or proof of continuing disability. **We** will deny **your** claim, or stop sending **you** payments, if the appropriate information is not submitted within 45 days of the request. **You** or **your Employer** must notify **us** immediately when y**ou** return to work in any capacity.

MAKING PAYMENTS

Once **your** claim has been approved, **we** will send **you** a payment at the end of each month for any period for which **we** are liable.

OVERPAID CLAIMS

We have the right to recover any overpayments due to:
1. fraud;
2. any administrative error **we** make in processing a claim; or
3. **your** receipt of **deductible sources of income**.

You must reimburse **us** in full. **We** will determine the method by which the repayment is to be made.
We will not recover more money than the amount **we** paid **you**. However, **we** reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under the policy.

APPLICATION FOR GROUP INSURANCE

120 ROYALL STREET • CANTON MA 02021

BOSTON MUTUAL LIFE INSURANCE COMPANY 1891

GROUP POLICY NO: G- 54784

1. Legal Name of Applicant: Town Of Wayland the Policyholder

2. Requested Effective Date: 11/1/18

3. Applicant is a: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Trusteeship ☐ Association ☐ Subchapter S ☒ Government Entity

4. Nature of Business: Executive Offices

5. Subsidiary or Affiliated Companies to be covered. (In case of trusteeship or association, attach contributing Employers/Members):

Name	Address	Relationship to Applicant	Subsidiary or Affiliate

6. Address: 41 Cochituate Road Wayland MA 01778
Street City State Zip

7. Billing Address:
(If different than above) Street City State Zip

8. Primary Contact Name: Donna Lemoyne Title: HR Manager

9. Telephone: 508-358-3612 Fax: (508)358-3627 Email: dlemoyne@wayland.ma.us

10. Premiums will be paid day of the month according to the following schedule: ☒ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

11. Initial Deposit Amount: $

12. Requested Coverages: ☒ Group Life - Including Waiver of Premium ☒ Yes ☐ No ☐ Group Short Term Disability
☒ Group Accidental Death & Dismemberment 24 Hour ☒ Group Long Term Disability

13. Does this requested coverage replace existing insurance? ☒ Yes ☐ No If yes, please specify each coverage and insurance carrier below:

Employee Class	Type/Amount of Coverage	Insurance Carrier	Effective Date	Termination Date
Active	LTD	UNUM	11/1/2018	

14. Continuity of Coverage for LTD: ☒ Yes ☐ No (If yes, attach copy of prior carrier's booklet) Termination Date:

15. a. Total Eligible Employees 671. b. Employees must work a minimum of 20 regularly scheduled hours per week.

16. Waiting Period for Eligible Employees:

Employee Class and/or Coverage	New Employees	Current Employees	Effective 1st of the Month Following Yes/No

A person must be Actively at Work as of the effective date of this policy and on their eligibility date to be covered for insurance requested. If a person is not Actively At Work coverage will not become effective until he/she is returned to active employment.

17. Changes in employee's insurance shall become effective: ☒ on the 1st day of the insurance month next following date of change
☐ upon the anniversary date of the group policy

☐ other please specify

18. If applicable, name and address of Third Party Administrator:

19. Is Boston Mutual preparing W-2 Forms for employees receiving disability benefits under this policy: a. Short Term Disability ☐ Yes ☐ No
b. Long Term Disability ☐ Yes ☒ No

PLEASE NOTE:

- A separate election must be authorized for each unique group policy and division thereof.
- Having Boston Mutual prepare your W-2 forms for your employees receiving disability benefits does not release you of your obligation to file a "Third-Party Sick Pay Recap" W2 and W-3 form. These recap forms are needed to reconcile employer match of FICA you have paid in on behalf of your employees.
- If you request that Boston Mutual Life prepare your W-2 forms for third party sick pay benefits paid to your employees, you agree that such forms will be prepared using Boston Mutual Life's name and employer identification number or its Third party vendor.
- This election will remain in effect until amended or canceled in writing.

COMMENTS - SPECIAL REQUESTS:

Do not change the billing contact of Gayle Stahl, 508-358-3614, gstahl@wayland.ma.us

IT IS UNDERSTOOD AND AGREED THAT:

1. THE GROUP INSURANCE WILL BECOME EFFECTIVE ON THE DATE REQUESTED ONLY IF THIS APPLICATION IS ACCEPTED AT THE HOME OFFICE OF BOSTON MUTUAL LIFE INSURANCE COMPANY IN CANTON, MASSACHUSETTS;
2. THE CONDITIONS OF ELIGIBILITY, THE CONDITIONS UNDER WHICH INSURANCE FOR ANY PERSON BEGINS AND ENDS, THE INSURANCE COVERAGE, BENEFITS AND AMOUNTS, THE CONDITIONS UNDER WHICH THE BENEFITS WILL BE PAYABLE, AND OTHER TERMS AND CONDITIONS WILL BE IN ACCORDANCE WITH THE POLICY(IES) ISSUED AND ANY AMENDMENTS, RIDERS, OR ENDORSEMENTS THERETO; AND
3. THE POLICY(IES) ISSUED AND ANY AMENDMENTS, RIDERS, EXHIBITS OR ENDORSEMENTS THERETO, TOGETHER WITH THE COPY OF THIS APPLICATION, SCHEDULE OF BENEFITS AND COST EXHIBIT TO BE ATTACHED TO THE POLICY(IES) AND THE INDIVIDUAL APPLICATIONS, IF ANY, OF THE PERSONS TO BE INSURED, WILL CONSTITUTE THE ENTIRE CONTRACT.

Dated at: Wayland, MA
City, State

06/18/18
Month – Day – Year

James A Flynn
Licensed Agent/Agency Name (print)

Nan Balmer
Full Name of Applicant's Authorized Representative (print)

Signature of Agent or Authorized Agency Representative

Nan Balmer
Signature of Applicant's Authorized Representative

SSN/TIN

National Producer Number

Town Administrator
Title of Applicant's Authorized Representative (print/type)

FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

IIPRC Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

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

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

MAINE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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

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

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

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

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

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

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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

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

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

Addendum #1

Annual Enrollment Period for Incremental Voluntary Coverage

Policyholder Name:**Town of Wayland**

This addendum applies to the following coverage(s)

☐ Voluntary Life & AD&D Coverage

☐ Voluntary Short Term Disability Coverage

☒ Voluntary Long Term Disability Coverage

Coverage	Increment Value
Voluntary Life & AD&D	
Voluntary Short Term Disability	
Voluntary Long Term Disability	**$100**

Employees currently enrolled for voluntary coverage may enroll for an additional two increments as long as this amount does not exceed the guarantee issue amount as stipulated within the Master Policy. For Disability coverage, the amount elected must also be below the maximum benefit percentage as outlined in the Master Policy.

Employees who did not previously enroll when first eligible for voluntary coverage are required to submit satisfactory Evidence of Insurability for all voluntary coverage amounts requested.

This annual enrollment does not apply to employees who requested coverage under this plan previously and were declined by Boston Mutual.

This annual enrollment applies to employees only.

For all disability coverage increases the Pre Existing Condition limitation will be applied to all increases in coverage *(if applicable as shown in the Master Policy)*

Coverage in excess of the amounts listed here may be available provided the applicant submits satisfactory Evidence of Insurability to Boston Mutual.

For employees age 70 and over, all coverage requests will be subject to satisfactory Evidence of Insurability.

In all cases, coverage amounts above the maximum as stipulated by coverage within the master contract will not be allowed.

The annual enrollment will be **May 1** through **May 31** with an effective date of **July 1** each year.

Additional Comments

SCHEDULE OF BENEFITS FOR TOWN OF WAYLAND

PLAN ID: Voluntary LTD - Incremental Benefits
PROPOSED EFFECTIVE DATE: November 1, 2018

GROUP PARTICIPATION REQUIREMENTS:
The greater of 10 lives or 25% of eligible employees.

LTD Class 1: All Full Time Active Employees electing option 1

BENEFIT:

Class Participation Requirement	25%
Benefit Percent	60%
Coverage Amount	Elected in $100 increments
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	Greater of $100 or 10%
Guaranteed Issue	$6,000
Elimination Period	90 Days or after the end of sick leave, whichever is greater
Benefit Duration	ADEA II 65/5/70
Social Security Integration	Primary/Family
Pre-Existing Exclusion	3/12
Own Occupation Period	2 Years
Definition of Disability	Res 12 Months WB
Mental Illness Limitation	24 Months
Drug and Alcohol Limitation	24 Months
Self Reporting Limitation	Unlimited
Survivor Benefit	3 Months
Family Care Benefit	YES
Family Care Benefit Amount	$350 PER CHILD TO A MAXIMUM OF $1,000 PER MONTH
Family Care Benefit Duration	12 Months
EE Contribution	100%

- Having Boston Mutual Life Insurance Company prepare your W-2 forms for your employees receiving long-term disabilities does not release you of your obligation to file a 'Third-Party Sick Pay Recap' W-2 and W-3 form. These recap forms are needed to reconcile employer match of FICA you have paid in on behalf of your employees.

- If you request that Boston Mutual Life Insurance Company prepare your W-2 forms for third party sick pay benefits paid to your employees, you agree that such forms will be prepared using Boston Mutual Life Insurance Company's name and employer identification number or its Third party vendor.

Stated policy specifications will be made part of the application.

120 ROYALL STREET * CANTON, MA 02021 * TEL 800-669-2668 * FAX 781-770-0497 * WWW.BOSTONMUTUAL.COM

COST EXHIBIT PAGE FOR TOWN OF WAYLAND

PLAN ID: Voluntary LTD - Incremental Benefits
PROPOSED EFFECTIVE DATE: November 1, 2018

MONTHLY EMPLOYEE PREMIUM PER $100 MONTHLY BENEFIT:

Age	Rate
Less than 25	$0.250
25 - 29	$0.326
30 - 34	$0.490
35 - 39	$0.643
40 - 44	$0.797
45 - 49	$1.085
50 - 54	$1.402
55 - 59	$1.709
60 and older	$1.853

- For Age Banded Price Option premium rates are based on attained age and change as each insured moves to a higher age bracket.
- It is assumed that this Proposal has been prepared for a group which has been in business for at least 2 years, unless otherwise approved by Home Office Underwriting.
- To be considered for coverage, applicants must have a legal right to reside in the United States, must have a permanent United States residential address and must have a (SSN) Social Security Number or (ITIN) Individual Tax Identification Number.
- The proposed rates are based upon the census data provided to Boston Mutual. Final rates will be based upon the actual enrollment census.
- Rates have a guarantee of 20 months.
- This Proposal is valid until February 10, 2019.
- Insurance applied for shall not take effect until the Application has been approved by Boston Mutual at its home office.
- Eligible Employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to Active Work.
- This proposal is intended to explain certain portions of the coverage. It does not constitute the policy. Any discrepancies between this proposal and the policy will be resolved by the wording contained in the policy.State variations to plan design and /or benefit maximums, exclusions and limitations may apply.
- Earnings means your gross income from your employer in effect just prior to your date of disability. It includes your total income before taxes and any deductions for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account.
  LTD: It does not include income received from commissions, bonuses, overtime pay, or any other extra compensation or income received from sources other than your employer.
- Limited open enrollment may be available subject to Boston Mutual Home Office Underwriting approval prior to the effective date of the group.

Stated policy specifications will be made part of the application.

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SCHEDULE OF BENEFITS FOR TOWN OF WAYLAND

PLAN ID: Voluntary LTD - Incremental Benefits
PROPOSED EFFECTIVE DATE: November 1, 2018

GROUP PARTICIPATION REQUIREMENTS:
The greater of 10 lives or 25% of eligible employees.

LTD Class 1: All Full Time Active Employees electing option 2

BENEFIT:

Class Participation Requirement	25%
Benefit Percent	60%
Coverage Amount	Elected in $100 increments
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	Greater of $100 or 10%
Guaranteed Issue	$6,000
Elimination Period	180 Days or after the end of sick leave, whichever is greater
Benefit Duration	ADEA II 65/5/70
Social Security Integration	Primary/Family
Pre-Existing Exclusion	3/12
Own Occupation Period	2 Years
Definition of Disability	Res 12 Months WB
Mental Illness Limitation	24 Months
Drug and Alcohol Limitation	24 Months
Self Reporting Limitation	Unlimited
Survivor Benefit	3 Months
Family Care Benefit	YES
Family Care Benefit Amount	$350 PER CHILD TO A MAXIMUM OF $1,000 PER MONTH
Family Care Benefit Duration	12 Months
EE Contribution	100%

- Having Boston Mutual Life Insurance Company prepare your W-2 forms for your employees receiving long-term disabilities does not release you of your obligation to file a 'Third-Party Sick Pay Recap' W-2 and W-3 form. These recap forms are needed to reconcile employer match of FICA you have paid in on behalf of your employees.

- If you request that Boston Mutual Life Insurance Company prepare your W-2 forms for third party sick pay benefits paid to your employees, you agree that such forms will be prepared using Boston Mutual Life Insurance Company's name and employer identification number or its Third party vendor.

Stated policy specifications will be made part of the application.

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COST EXHIBIT PAGE FOR TOWN OF WAYLAND

PLAN ID: Voluntary LTD - Incremental Benefits
PROPOSED EFFECTIVE DATE: November 1, 2018

MONTHLY EMPLOYEE PREMIUM PER $100 MONTHLY BENEFIT:

Age	Rate
Less than 25	$0.144
25 - 29	$0.211
30 - 34	$0.326
35 - 39	$0.442
40 - 44	$0.557
45 - 49	$0.778
50 - 54	$1.000
55 - 59	$1.200
60 and older	$1.277

- For Age Banded Price Option premium rates are based on attained age and change as each insured moves to a higher age bracket.
- It is assumed that this Proposal has been prepared for a group which has been in business for at least 2 years, unless otherwise approved by Home Office Underwriting.
- To be considered for coverage, applicants must have a legal right to reside in the United States, must have a permanent United States residential address and must have a (SSN) Social Security Number or (ITIN) Individual Tax Identification Number.
- The proposed rates are based upon the census data provided to Boston Mutual. Final rates will be based upon the actual enrollment census.
- Rates have a guarantee of 20 months.
- This Proposal is valid until February 10, 2019.
- Insurance applied for shall not take effect until the Application has been approved by Boston Mutual at its home office.
- Eligible Employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to Active Work.
- This proposal is intended to explain certain portions of the coverage. It does not constitute the policy. Any discrepancies between this proposal and the policy will be resolved by the wording contained in the policy.State variations to plan design and /or benefit maximums, exclusions and limitations may apply.
- Earnings means your gross income from your employer in effect just prior to your date of disability. It includes your total income before taxes and any deductions for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account.
  LTD: It does not include income received from commissions, bonuses, overtime pay, or any other extra compensation or income received from sources other than your employer.
- Limited open enrollment may be available subject to Boston Mutual Home Office Underwriting approval prior to the effective date of the group.

Stated policy specifications will be made part of the application.

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