TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT CERTIFICATE
SCHEDULE OF BENEFITS

EPIC certifies that you and, if dependent term life coverage is indicated on this EPIC Schedule of Benefits issued with this certificate, any covered dependents are insured for covered expenses as described in this certificate as of the effective date shown in our records, subject to the terms, conditions, exclusions, limitations and all other provisions of the policy.

If the term NONE or N/A (Not Applicable) appears in this schedule, that coverage or provision doesn't apply to you, and no benefits are payable under that coverage or that provision doesn't apply to the policy.

Beneficiary is the person identified by name by the insured in his/her EPIC enrollment application or most recent beneficiary change designated by the insured.

1. Your Term Life Coverage:

a. Applicable ($25,000)

b. Eligible Employee Reduction: Benefit is reduced by 35% at age 65, and an additional 15% at age 70

2. Your Accidental Death and Dismemberment (AD&D) Coverage:

a. Applicable ($25,000)

b. Employee Reduction: Benefit is reduced by 35% at age 65, and an additional 15% at age 70

3. Dependent Term Life Coverage:

a. Applicable (Spouse $25,000) (Child $10,000)

b. Spouse Reduction: Benefit is reduced by 35% at age 65, and an additional 15% at age 70

c. Dependent Child Reduction: From one to 14 days, there is no benefit payable. From 15 days to six months, the benefit will be 10% of the dependent child's volume.

4. Temporary or Seasonal Layoff or Approved Leave of Absence: Your coverage may continue for 3 policy months after the last day of the policy month in which temporary or seasonal layoff or approved leave of absence occurs.

5. Accelerated/Living Benefit Coverage:

a. Discount: $300

b. 50% of the death benefit

c. $50,000 Maximum Accelerated/Living Benefit

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT CERTIFICATE

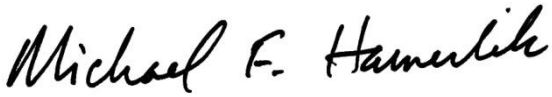
Please read this certificate, including the Schedule of Benefits and all endorsements, if any, carefully, so you know and understand your coverage.

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group term life insurance policy (hereinafter called "group policy" or "policy") issued by The EPIC Life Insurance Company (EPIC) to the group policyholder (hereinafter called "group policyholder" or "policyholder"). This certificate describes the essential features of such insurance. This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to you prior to the effective date of this certificate.

EPIC, in performing its obligations under the policy, is acting only as a life insurer with respect to the policy and is not in any way acting as a plan administrator, a plan sponsor or a plan trustee for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other federal or state law.

The policy is issued by EPIC and delivered to the policyholder. All terms, conditions and all other provisions of the policy are governed by the laws of the state in which the policyholder is located. All benefits are provided in accordance with the terms, conditions, exclusions, limitations and provisions of the policy, including all endorsements, if any, attached to this certificate, and applicable laws and regulations of the state in which the policyholder is located.

THE EPIC LIFE INSURANCE COMPANY



Michael F. Hamerlik, President

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GENERAL INFORMATION

General Description of Coverage

EPIC certifies that a group policy has been issued to a group insuring certain employees of the group. We call the group the policyholder. Those persons to whom we've issued certificates are called covered employees. Covered employees are also called members. If a covered employee is issued family coverage under the group policy, his/her eligible dependents whom we approved for coverage are also called members. The group policy forms a contract between us and the policyholder. We'll provide the insurance described here under the terms, conditions and provisions of that contract. Subject to that contract, each member is insured for the coverage described in this certificate. Please see subsection "Entire Contract".

Coverage

Coverage is subject to terms, conditions, exclusions, limitations, and all other provisions of the policy. As a certificate, this document describes the essential features of the insurance provided by the policy, but does not constitute the actual policy. You may examine the policy at the office of the policyholder during regular business hours.

This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to the covered employee prior to the effective date of this certificate.

How to Use This Certificate

This certificate, including its Schedule of Benefits and all endorsements, should be read carefully and completely by you. You should also review this certificate periodically. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in section "Definitions". By understanding these definitions, you will have a clearer and better understanding of your coverage under the policy as described in this certificate by us.

From time to time the policy may be amended by us. When that happens, a new endorsement for this certificate will be sent by us to the policyholder for its delivery to each covered employee. That means your coverage under the policy will change to the extent described in the endorsement, as of the effective date of that endorsement. This certificate should be kept in a safe place for your future reference.

Payment of Benefits

EPIC has the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions, and all other provisions of the policy, including, but not limited to, making factual determinations under the policy's provisions, including, but not limited to, whether benefits are payable. At any time, we may, at our sole discretion, give certain discretionary authority to other persons or entities providing administrative services to us in regard to the policy. We reserve the right to change, interpret, modify, remove or add benefits, or terminate the policy, at our sole discretion, without giving prior notice to you, or getting your approval. Other than EPIC, no person or entity has any authority to make any oral changes or amendments to the policy. Please also see subsection "Waiver and Change."

We may, at our sole discretion, arrange for various persons or entities to provide administrative services in regard to the policy, including claims processing services. Their identity and the nature of the services being provided by them may be changed by us at any time at our sole discretion, and without giving prior notice to you, or getting your approval. By accepting this certificate, you agree to and must cooperate fully with those persons or entities in the performance of their responsibilities.

If any amount of coverage payable to you is based on your salary, we will pay benefits based on the most current salary information provided to us from the policyholder prior to your death and for which premium has been paid.

DEFINITIONS

In this certificate the following terms shall mean:

Active Work/Actively at Work: when an employee is performing all of the full-time duties of his/her principal occupation in his/her job with the policyholder for the required number of hours per week as shown in the policyholder's current EPIC application for coverage, and paid a reasonable wage, as determined by us. These duties must be performed at the policyholder's place of business, except to the extent that the employee must travel to perform his/her duties, or an alternate location if approved by the policyholder. The employee shall be deemed to be actively at work on: (1) each day of a paid vacation; or (2) a regularly-scheduled non-working day, provided that, in either case, he/she has performed all of the full-time duties of his/her principal occupation in his/her job on a full-time basis on his/her entire last regularly-scheduled work day prior to such date.

Air Bag: an inflatable supplemental passive restraint system installed by the manufacturer of the automobile or proper replacement parts as required by the automobile manufacturer's specifications that inflates upon collision to protect an individual from injury and death. An airbag is not considered a seat belt.

Alcoholism: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 - Drug Dependence, and 305 - Nondependent abuse of drugs and 291 - Alcohol-induced Mental Disorders or 292 - Drug-Induced Mental Disorders.

Automobile: a duly registered, four wheeled, private passenger car, pick-up truck, van, self-propelled motor home or sport utility vehicle which is not being used as a common carrier.

Certificate: the document issued by us to the covered employee under the policy issued by us to the policyholder. It is not a contract of insurance, but only evidence of coverage, and describes the essential features of the insurance provided by the policy.

Common Carrier: a conveyance operated by a concern, other than the employer, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Complication of Pregnancy: a health condition needing medical treatment before or after termination of pregnancy. The health condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: medically necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia. Complication of pregnancy does not include: false labor; occasional spotting; rest prescribed during period of pregnancy; elective caesarean section.

Confinement/Confined: the period starting with a member's admission on an inpatient basis (more than 24 hours) to a hospital or other licensed health care facility for treatment of an illness or injury. Confinement ends with his/her discharge from the same hospital or other facility. If a member is transferred to another hospital or other facility for continued treatment of the same or related illness or injury, it's still just one confinement.

Covered Employee: an employee who meets all of the following requirements: (1) he/she is employed by the policyholder; (2) he/she is eligible for coverage under the policy; (3) he/she has properly enrolled; and (4) he/she is approved by us for coverage under the policy; and for whom we've accepted the appropriate premium paid by the policyholder.

Date of Disability: the date on which you are seen, treated and certified as totally disabled by your attending physician. It does not include the last day you worked unless: (1) you worked less than ½ of your normal regularly-scheduled work hours for the policyholder on that day; and (2) you became totally disabled on the same day.

Dependent: see subsection "Eligible Dependent" for dependent eligibility.

Drug Abuse: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within a classification category or code 303 - Alcohol Dependence Syndrome, 304 - Drug Dependence, and 305 - Nondependent abuse of drugs and 291 - Alcohol-induced Mental Disorders or 292 - Drug-Induced Mental Disorders.

Employee: see subsection "Eligible Employee" for employee eligibility.

Enrollment Date: the effective date of coverage under the policy or the first day of the probationary period, if any, as shown in the policyholder's current application for coverage whichever is the earlier. A late enrollee's enrollment date will always be his/her effective date of coverage under the policy.

Enrollment Period: the period beginning immediately following an eligible employee's enrollment date through the 31st day immediately following the end of his/her probationary period, if any.

EPIC: The EPIC Life Insurance Company with its principal office located in Madison, Wisconsin.

Group Master Policy/Policy: the insurance policy issued by us to the employer, trustee, union, association, organization or other entity known as the group policyholder. In it, we agree to insure members of the group policyholder for future losses covered by the policy through benefit payments, subject to the terms, conditions, and provisions of the policy.

Illness or Sickness: a physical illness, alcoholism, drug abuse, a disease, a nervous or mental disorder, complication of pregnancy, or pregnancy which requires treatment by a physician.

Immediate Family: your spouse, natural and adopted child(ren), child, parents, grandparents, brothers and sisters and spouses of such persons.

Injury: an injury that is sustained by you which is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurs while the insurance coverage is in force.

Member: a covered employee or his/her eligible dependents who have been enrolled and approved by us for coverage under the policy.

Nervous or Mental Disorders: a health condition listed in the latest edition of the International Classification of Disease (ICD-9-CM) within one of the following classification categories or codes: 295 - Schizophrenic Disorders; 296 - Episodic Mood Disorders; 297 - Delusional Disorders; 298 - Other Nonorganic Psychoses; 300 - Anxiety, Dissociative and Somatoform Disorders; 301 - Personality Disorders; 302 - Sexual and Gender Identity Disorders; 306 - Physiological Malfunction Arising From Mental Factors; 307 - Special Symptoms or Syndromes, Not Elsewhere Classified; 308 - Acute Reaction to Stress; 309 - Adjustment Reaction; 311 - Depressive Disorder, Not Elsewhere Classified; 312 - Disturbance of Conduct, Not Elsewhere Classified; 313 - Overanxious Disorder; and 314 - Hyperkinetic Syndrome of Childhood.

Physical Illness: a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body. Physical illness includes pregnancy and complications of pregnancy. Physical illness does not include alcoholism, drug abuse, or a nervous or mental disorder.

Physician: a person who received a degree in medicine from an accredited college or university and is a medical doctor or surgeon licensed by the state in which he/she is located and provides health care services while he/she is acting within the lawful scope of his/her license. When we are required by law to cover the services of any other licensed medical professional under the policy, a physician also includes such other licensed medical professional who: (1) is licensed by the state in which he/she is located; (2) is acting within the lawful scope of his/her license.

Salary: your standard rate of pay for one year provided to us by the policyholder at the time of your death which is confirmed by: (1) your most recent W2 form; and (2) the amount of premium submitted by the policyholder based on that salary.

Seat Belt: an unaltered belt, lap restraint, or lap shoulder restraint installed by the manufacturer of the automobile or proper replacement parts as required by the automobile manufacturer's specifications.

Totally Disabled/Total Disability: this means you are unable due to illness or injury to perform the essential functions of any full-time job with the policyholder, as determined by us. You are not totally disabled if you are working on either a full-time or part-time basis for wage or profit for anyone, including working for yourself. For dependents and retired employees, this means the person's inability due to illness or injury to carry on most of the normal activities of a person of the same age and sex, including, but not limited to, being unable to work on either a full-time or part-time basis for wage or profit for anyone, including working for himself/herself, as determined by us. The totally disabled person must be under the regular care of a physician. We have the right

to examine such person, including having health care providers examine that person, as often as we reasonably require for us to determine whether or not that person is totally disabled. We will pay for those examinations.

We, us, our: The EPIC Life Insurance Company.

You, your: a covered employee.

ELIGIBILITY

Eligible Employee

An eligible employee is a person who: (1) is a member of a class shown in the policyholder's current EPIC application for coverage; (2) whose name and related employment information appears on the policyholder's regular payroll records as being a current full-time employee of that employer (excluding employees working on a seasonal or temporary basis); and (3) performs all of the duties of his/her principal occupation in his/her job with the policyholder for at least the minimum number of hours per week as shown in the policyholder's current EPIC application for coverage.

An employee is eligible for coverage under the policy if he/she: (1) is actively at work and performs all of the duties of his/her principal occupation in his/her job with the policyholder and paid at least the minimum wage required by law for at least the minimum number of hours per week as shown in the policyholder's current EPIC application for coverage; (2) is actively performing all such duties on the effective date of his/her coverage under the policy; and (3) has completed his/her probationary period, if any, as shown in the policyholder's current EPIC application for coverage.

Eligible Dependent (Dependent Life Coverage, if Applicable)

An eligible dependent is a person who is a citizen of the United States or a resident legal alien and who is: (1) the your spouse; (2) your unmarried natural child, adopted child, child placed for adoption with you, step-child or legal ward over 14 days old but under the applicable age shown in Section 3. b. of the Schedule of Benefits for dependent children; and (3) your unmarried natural child, adopted child, child placed for adoption with you, step-child or legal ward over 14 days old, but under the applicable age shown in Section 3. b. of the Schedule of Benefits for dependent students, if he/she is a full-time student as determined by us. If a dependent child becomes an eligible employee of the policyholder, his/she is no longer eligible as a dependent and must make application as an eligible employee for coverage under the policy. A person is not an eligible dependent if he/she is: (1) covered under the policy as a covered employee; (2) on active duty with the military service, including national guard or reserves, other than for duty of less than 30 days; or (3) in the case of a child: (a) if such child provides 50% or more of his/her own support, as determined by us; or (b) such child is no longer eligible if adopted or placed for adoption and insured under the adopting person's coverage. No person shall be considered as an eligible dependent of more than one covered employee.

MEMBER EFFECTIVE DATES

If application for coverage is properly made on our application form or other documentation approved by us by an eligible employee and the required premium for his/her coverage is submitted to EPIC, the effective date of coverage to be issued under the policy for that eligible employee and his/her eligible dependents, if any, shall be determined by EPIC as follows:

1. Initial Enrollees.

An initial enrollee is an eligible employee who enrolls during the commencement of the policyholder's initial enrollment period with EPIC. An initial enrollee's effective date shall be the policy's effective date. The eligible employee must be actively at work with the policyholder on his/her effective date of coverage under the policy. An initial enrollee shall

include an eligible employee's dependent provided the eligible employee has applied for dependent term life coverage under the policy, and dependent term life coverage is available to the employee.

2. New Entrants.

A new entrant's effective date of coverage under the policy will be determined by us as follows:

a. Eligible Employees. An eligible employee shall become insured as indicated in the policyholder's current application of coverage, if he/she applies for coverage under the policy within 31 days after the completion of his/her probationary period, if any, as shown in the policyholder's current application for coverage. The application must be received by EPIC within the enrollment period. However, if the application is received by us after his/her enrollment period ends, that employee is a late enrollee. Please see paragraph 3. below.

The eligible employee must be actively at work with the policyholder on his/her effective date of coverage under the policy.

b. Eligible Dependents. Provided the eligible employee has applied for dependent term life coverage under the policy, and dependent term life coverage is available to the employee, each of his/her eligible dependents shall become insured as a member on the date the dependent becomes eligible if application is received by us within 31 days of the dependent's eligibility date. If we do not receive the application for the dependent's coverage within 31 days of the dependent's eligibility date, that dependent shall be considered a late enrollee. However, if an eligible dependent who would otherwise become insured is confined in a hospital or at home or is totally disabled on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she ceases to be confined in a hospital or at home and is not totally disabled.

If dependent life coverage is in effect on the date of birth of your newborn child or the date you adopt a child, coverage for such child is effective as of that 15th day following the birth of the newborn child or, for an adopted child who is 15 days old or older: (1) on the date that a court makes a final order granting adoption of the child by you; or (2) on the date that the child is placed for adoption with you, whichever occurs first.

3. Late Enrollees.

A late enrollee may make written application to us at any time, subject to our health underwriting requirements, including our approval of his/her application and satisfactory evidence of insurability he/she may have to submit to us. If we approve the late enrollee for coverage under the policy, his/her effective date shall be the first day of the calendar month following the date we approve him/her. If we do not approve the person for coverage, we will advise the policyholder that he/she was not accepted by us, and he/she shall not be insured under the policy.

A late enrollee must apply using our application form and pay the required premium for his/her coverage. Benefits are subject to any applicable waiting periods for pre-existing conditions.

However, if an otherwise eligible employee is not actively at work on the date his/her coverage would otherwise become effective under the policy, his/her coverage shall not become effective until the earliest later date he/she is eligible and is actively at work with the policyholder.

WHEN YOUR COVERAGE ENDS

As determined by us, your coverage under the policy shall end automatically without notice at midnight central standard time at the main office of the policyholder on the earliest of the following dates:

1. the date the policy ends;

2. the day immediately following the last day of the calendar month for which premium required for your coverage has been paid to us in accordance with the policy;

3. the date you enter into the military service other than for duty of less than 30 days; or

4. the day immediately following the last day of the calendar month in which you request that your coverage terminate, or

5. the date you die;

6. the day immediately following the last day of the calendar month in which your employment is terminated. For purpose of this section and for no other purpose, termination of employment means you cease to be actively at work for the policyholder and no longer an employee who's a member of an eligible class of employees, as determined by the policyholder using its accurate and complete payroll and related employment records, including the date on which:

a. you resign or retire;

b. you are no longer in an eligible class; or

c. you do not satisfy: (1) the requirements for hours worked; or (2) any other eligibility conditions in the policy; except that, your life and accidental death and dismemberment (AD&D) coverage may be continued while you are on temporary or seasonal lay-off or approved leave of absence. The policyholder must notify us in advance of the date of your temporary or seasonal lay-off or approved leave of absence. Your life and AD&D coverage under the policy shall continue until premium payments for such coverage(s) are discontinued by the policyholder. In no case shall your coverage continue beyond the period of time shown in Section 4. of the Schedule of Benefits; or

However, if you cease to be an eligible employee as defined in the policy because of disability due to illness or injury, as determined by the policyholder, your employment may be continued during the continuance of such disability until terminated by the policyholder, but that period of employment continuation shall not exceed 12 months. If your employment is continued by the policyholder by reason of your continuing disability, your coverage shall continue for that same period, but the continuation of coverage under these circumstances shall not exceed 12 months.

If you cease to be actively at work for any reason specified in 6. above, your insurance may be continued as provided in 6. above only on a basis which shall preclude discrimination against any other employee.

The policyholder must notify us in advance of the effective date of your temporary or seasonal lay-off or approved leave of absence.

WHEN DEPENDENT COVERAGE ENDS

If applicable, your dependent's coverage will end under the policy at midnight central standard time at the main office of the policyholder on the earliest of the following dates:

1. the day he/she ceases to be a dependent as defined in the policy;

2. the date of a valid decree of divorce or annulment with respect to the dependent spouse;

3. the day your coverage ends;

4. the day immediately following the last day of the calendar month for which any premium for your dependent term life coverage is due and unpaid;

5. the day immediately following the last day of the calendar month in which we receive a request that the dependent term life coverage terminates;

6. the day the policy ends;

7. the day you resign, retire or die;

8. the day he/she dies; or

9. the date he/she enters into the military service other than for duty of less than 30 days.

BENEFITS

Term Life Coverage

1. Your Benefits.

Subject to all terms, conditions and provisions of the policy, the coverage described in this paragraph 1. applies only if shown as being applicable in Section 1. a. of the Schedule of Benefits.

We will pay benefits in the amount of coverage in force on you at the time of your death to your beneficiary(ies) (if more than one beneficiary is designated, benefits will be divided equally among any surviving beneficiaries, unless otherwise specified) if we receive satisfactory notice of a claim, the completed claim form, and all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records, accident reports, autopsy results, and other reports.

If a beneficiary is not named on your application or in any other manner prearranged by us as acceptable, we will determine the beneficiary and pay benefits to the first available individual or individuals using the following naming sequence:

a. widow or widower

b. children (natural children or legally adopted). If at least one child survives you, the share of any deceased child is payable to the surviving spouse of the child or to the surviving children of the child if there is no spouse, or otherwise to the other children in this family.

c. grandchild or grandchildren

d. parent(s)

e. brother(s) and sister(s)

If there are no survivors in a. through e. above, death benefits will be paid to your estate.

Benefits are paid in a lump sum to the designated beneficiary as indicated in our records. However, other arrangements for a different mode of payment may be made, subject to our prior written approval.

The benefit payable for term life coverage on your life is the amount equal to:

a. the base term life amount shown in the policyholder's most current application for coverage up to the guaranteed issue amount. This amount may be equal to a multiple of salary or a specific dollar amount selected by the policyholder; plus

b. the supplemental term life guaranteed issue amount, if applicable, shown in your most current application for coverage and approved by us; or

c. the voluntary term life guaranteed issue amount shown in your most current application for coverage and approved by us; plus

d. any amounts applied for over the guaranteed issue amount approved by us.

The amounts stated above are subject to any reductions shown in Section 1. b. of the Schedule of Benefits. If an age reduction applies, the benefit reduces on the date you become that age.

2. Dependent Benefits.

Subject to all terms, conditions and provisions of the policy, the coverage described in this paragraph 2. applies only if shown as being applicable in Section 3. a. of the Schedule of Benefits.

If an insured dependent dies while covered for term life coverage under the policy, we will pay benefits in the amount of coverage in force on that insured dependent at the time of his/her death:

a. to you, if living; or

b. to your estate,

if we receive satisfactory notice of a claim, the completed claim form, and all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records, accident reports, autopsy results, and other reports.

Benefits are paid in a lump sum. However, other arrangements for a different mode of payment may be made, subject to our prior written approval.

The benefit payable for dependent term life coverage is the amount equal to:

a. the base dependent term life amount shown in the policyholder's most current application for coverage; or

b. the voluntary dependent term life amount shown in your most current application for coverage and approved by us; plus

c. the supplemental dependent term life amount, if applicable, shown in your most current application for coverage and approved by us.

The amounts stated above are subject to any reductions shown in Section 3. c. and 3. d. of the Schedule of Benefits. If an age reduction applies, the benefit reduces on the date the dependent becomes that age.

3. Waiver of Premium.

If you become totally disabled, your term life coverage will not end in accordance with section "When Your Coverage Ends", but will be continued without payment of premium, provided we determine that:

a. your total disability began while you were insured under this provision;

b. your total disability began before you reached age 60; and

c. proof of your total disability is given to us as described in the following paragraph; and

d. the policy continues in force during the entire period of your total disability.

You should send us notice of your total disability not sooner than the ninth through the twelfth month of disability. We will then send you the initial proof of total disability form for you e and your attending physician to complete. Upon our receipt and our determination that you are totally disabled based on all the available information, including the completed proof of total disability form, we will continue your term life coverage for a period of one year, provided the policy stays in force for the entire period. We will notify you by letter of our decision as soon as reasonably possible after we make our decision. Thereafter, you and your physician must submit yearly proof that you are totally disabled. The proof must be submitted during the three-month period before the anniversary date of our letter. If your subsequent proof is acceptable to us, your term life coverage will be continued for further terms of one year. However, your coverage will not be continued beyond the date you are no longer totally disabled or you reach your 70th birthday, whichever is earlier.

If you die before proof of total disability is submitted to us and we determine that you were totally disabled, the amount of term life coverage will still be payable, provided:

a. your death was within 12 months from the day your term life coverage would have otherwise ended in accordance with section "When Your Coverage Ends"; and

b. we determine that your total disability was uninterrupted from the date insurance would otherwise have ended until your death.

Your continued term life coverage is the amount in force on the day your life coverage would have otherwise ended. Your continued term life coverage is subject to any reductions and terminations shown in Section 1. b. of the Schedule of Benefits.

In order for us to determine if you are totally disabled, we have the right to have you physically examined by a physician of our choice, including, if necessary, psychiatric examinations. We will pay for these examinations. We may have you examined any time during the first two years of your total disability and once a year from then on as determined by us.

Accidental Death and Dismemberment (AD&D) Benefits

Subject to all terms, conditions, and provisions of the policy, the coverage described in this subsection applies only if shown as applicable in Section 2. a. of the Schedule of Benefits.

1. Group AD&D Benefits.

If we determine you incur a covered loss:

a. while insured for this AD&D coverage under the policy; and

b. due solely to an injury incurred while you are covered under the policy; and

c. within 90 days immediately following the date of the injury;

we will pay benefits in the amount specified below.

The maximum benefit for any combination of two or more of the losses described below due to the same injury is described below based on the AD & D amount. The AD & D amount is equal to:

a. the AD & D amount shown in the policyholder's most current application for coverage up to the guaranteed issue amount. This amount may be equal to a multiple of salary or a specific dollar amount selected by the policyholder; plus

b. the supplemental term life guaranteed issue amount, if applicable, shown in your most current application for coverage and approved by us; or

c. the voluntary AD & D guaranteed issue amount shown in your most current application for coverage and approved by us; plus

d. any amounts applied for over the guaranteed issue amount approved by us.

The AD & D amount is subject to any reductions shown in Section 2. b. of the Schedule of Benefits. If an age reduction applies, the benefit reduces on the date you become that age.

LOSS	BENEFIT PAYABLE
Loss of life	AD&D Amount

Loss of one hand (permanent severance at or above the wrist)	50% of AD&D Amount
Loss of one foot (permanent severance at or above the ankle)	50% of AD&D Amount
Irrevocable loss of sight in one eye	50% of AD&D Amount
Irrevocable loss of speech or hearing (hearing must be lost in both ears)	50% of AD&D Amount
Loss of a thumb and index finger on either hand (permanent severance through or above the metacarpophalangeal joints)	25% of AD&D Amount
Irrevocable loss of movement of both upper and lower limbs (Quadriplegia)	AD&D Amount
Irrevocable loss of movement of three limbs (Triplegia)	75% of AD&D Amount
Irrevocable loss of movement of both lower limbs (Paraplegia)	75% of AD&D Amount
Irrevocable loss of movement of both upper and lower limbs on one side of the body (Hemiplegia)	50% of AD&D Amount
Irrevocable loss of movement of one limb (Uniplegia)	25% of AD&D Amount
More than one of the above resulting from one accident	AD&D Amount or the sum of the benefits payable for each loss, whichever is less

The total of all payments ever made by us under this subsection for your loss(es) or death while insured under the policy cannot be more than the AD&D amount, subject to any reductions shown in Section 2. b. of the Schedule of Benefits. If payments eventually total that AD&D amount, coverage under this subsection will end for you as of the date of that last payment and no additional AD&D amount is payable.

2. Seat Belt Benefit.

If we determine you incur a covered loss while a passenger riding in; or the licensed operator of, an automobile and, at the time of the accident, you were properly wearing a seat belt and verified on the police report, then we will pay seat belt benefits in the amount specified below.

In addition to the AD&D Amount, the maximum benefit is the lesser of:

a. 10% of the AD&D Amount; or

b. $10,000.

3. Air Bag Benefit.

If we determine you incur a covered loss for which the seat belt benefit applies:

a. while positioned in a seat that was equipped with a factory installed air bag; and

b. while properly strapped in the seat belt when the air bag inflated; and

c. the police report establishes that the air bag inflated properly upon impact;

we will pay benefits in the amount specified below.

In addition to the AD&D Amount, an additional 5%, up to a maximum of $5,000.

4. Repatriation Benefit.

If we determine that you are eligible for the AD & D benefit and die outside the territorial limits of the state or country of your place of permanent residence, we will pay benefits in the amount specified below.

In addition to the AD&D Amount, the maximum benefit is the lesser of:

a. the expense incurred for preparation of your body for burial or cremation; and transportation of your body to the place of burial or cremation; or

b. 5% of the AD&D Amount; or

c. $5,000.

Accelerated/Living Benefit

Subject to all terms, conditions, and provisions of the policy, the coverage described in this subsection applies to you and your covered dependent spouse. This coverage is not available to your dependent children.

1. Definitions.

The following definitions apply to this subsection only:

Discount: the amount stated in Section 5. a. of the Schedule of Benefits. This amount is the administrative cost to EPIC in processing the accelerated/living benefit.

You, your: the covered employee or his/her covered spouse.

Terminal Condition: an irreversible condition caused by illness or injury which, in the medical judgment of a physician will directly result in a life expectancy of 12 months or less for you or your spouse, as determined by us.

2. Benefits.

This subsection provides for the accelerated payment of a portion of the death benefit under the policy.

If you are diagnosed with a terminal condition, you or your legal representative while you are living may request the accelerated/living benefit to be paid to you. To receive this benefit:

a. your coverage must be in force under the policy and all premiums due must be fully paid; and

b. an accelerated/living benefits request form must be completed by you or your legal representative and submitted to us;

c. we must receive a signed written acknowledgment and agreement from any assignee or irrevocable beneficiary agreeing to our payment of the accelerated/living benefit to you in accordance with this subsection; and

d. the information we have meets all of the requirements set forth in the policy.

If you have a medically approved terminal condition acceptable to us, we will pay the lesser of:

a. The percentage shown in Section 5. b. of the Schedule of Benefits of the death benefit shown in paragraphs 1. and 2. of subsection "Term Life Coverage", less the discount shown in Section 5. a. of the Schedule of Benefits; or

b. The maximum accelerated/living benefit amount shown in Section 5. c. of the Schedule of Benefits, less the discount as shown in Section 5. a. of the Schedule of Benefits.

The benefit payable shall be equal to the death benefit in force immediately prior to the payment of any accelerated/living benefit LESS the accelerated/living benefit paid and the applicable discount.

Premium payments for your coverage(s) must be continued to be paid to us on the full amount of the death benefit, except as specifically stated otherwise in the policy.

The exercise of your rights under this subsection is limited to one time only. Only one accelerated/living benefit can be paid to you.

Payment of any accelerated/living benefit, including the applicable discount, will reduce your term life benefits available under subsection "Term Life Coverage" and the amount available for you to convert to a conversion policy of life insurance as stated in subsection "Conversion Privilege".

Any accelerated/living benefit payment paid to you may be considered as taxable income to you. Your situation may be different and any questions on this subject should be discussed with your tax advisor. EPIC is not liable for any tax or tax penalty which may arise as a result of any accelerated/living benefit payment made pursuant under this subsection.

3. Payment of Benefits.

In order to receive payment of the accelerated/living benefits as stated in paragraph 2. above, you must submit to us: (a) the completed accelerated/living benefits request form; and (b) any additional information requested by us. Payment will be made in accordance with paragraph 2. above to you within 60 days following our receipt of a completed accelerated/living benefits request form and our determination that an accelerated/living benefit is payable to you in accordance with this subsection.

EXCLUSIONS

AD & D Exclusions

We will not pay any AD&D benefits for any loss due to:

1. any injury you receive while operating, riding in or descending from any aircraft, except as a fare-paying passenger in a commercial aircraft on a regularly scheduled flight;

2. any illness or sickness;

3. any bacterial infections (unless due to accidental food poisoning);

4. any accident involving racing or speed contests;

5. any injury sustained which is a probable, expected or a natural result of being legally intoxicated;

6. any injury sustained while under the influence of any controlled substance unless prescribed by and taken under the direction of a physician;

7. any loss which results, whether a member is sane or insane, from: (1) an intentionally self-inflicted injury or sickness; or (2) suicide or attempted suicide;

8. any loss resulting from your participation in a riot or in the commission of a crime;

9. any loss which results from weight control or any treatment of obesity;

10. any loss which results from an act of declared war or armed aggression; or

11. any loss incurred for which any government body or its agencies are liable, while you are on active duty or training in the Armed Forces, National Guard or Reserves, of any state or country.

Accelerated/Living Benefit Coverage

Accelerated/living benefits will not apply and are not payable in any of the following situations:

1. to you or your spouse's, if any, intentionally self-inflicted illness, injury, or suicide attempt;

2. if you or your spouse's, if any, required premiums for coverage under this policy is due and unpaid;

3. if you or your spouse, if any, has irrevocably assigned the applicable life benefit payable under the policy;

4. when all or a portion of the applicable life benefits payable under the policy are paid as part of a divorce settlement;

5. if you or your spouse's, if any, term life coverage has been in force for less than one year under the policy.

6. if you or your spouse, if any, is: (a) required by law to use the accelerated/living benefit to satisfy the claims of creditors, whether in bankruptcy or otherwise; or (b) required by a government agency to use this benefit to apply for, obtain or keep a government benefit or entitlement.

7. if the member who has the terminal condition is a dependent child. Coverage is available only to you and your covered spouse.

Term Life Coverage

We will not pay any term life benefits for any loss related to a member's suicide within two years from his/her effective date of coverage under the policy. We will return the total premium(s) paid to us for that member's coverage(s) under the policy during that period, to the person or entity who paid the premiums.

PAYMENT OF CLAIMS

How to File Claims

Before benefits are paid by us, we must be given written proof of claim as described below. In the event of your death or incapacity, your beneficiary or someone else may give us written proof of claim. Benefits payable under the policy will be paid as soon as reasonably possible after we receive the written proof of claim required to be submitted to us by the covered employee in accordance with subsection "Proof of Claim" below. We will decide whether benefits are payable on the claims submitted to us within a reasonable period of time after we receive the written proof of claim described in subsection "Proof of Claim" below, which allows us to make an informed decision as to whether benefits are payable. Any benefits paid by us in accordance with the policy shall fully discharge us from all further liability to the extent of benefits paid.

If there are circumstances which require that we have more time to determine our liability to pay benefits on such claim, we will send you written notice within 30 days of our receipt of such proof of claim, explaining why we need more time to review the charges. In that case, our decision on the claim will then be made within 120 days of our receipt of such proof of claim.

If you want to appeal the denial, such an appeal must be made in accordance with subsection "Claim Review Procedures" below.

If the claim is denied in whole or in part, you will receive a written notice from us with: (1) the specific reason(s) on which denial or partial denial is based; (2) the specific reference(s) to the policy provisions on which denial or partial denial is based; (3) a description of additional material or information which may be necessary for you to perfect your claim and an explanation of why such material or information is necessary; and (4) an explanation of how you may have the claim reviewed by us if you do not agree with our denial or partial denial.

Proof of Claim

1. Written proof of your claim includes: (a) the completed claim form required by us; (b) the certified death certificate and autopsy report; and (c) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and other reports. You should request a claim form from the policyholder or from us. This request should be made within 20 days after a loss occurs or as soon as reasonably possible.

When we receive the request, we will send a claim form for filing proof of loss. If we do not send it within 15 days, you can meet the proof of claim requirements by giving us a written statement of what happened. We must receive a written statement within the time shown in 3. below.

2. The claim form must be completed and signed. If a physician must complete part of the claim form, please have the physician complete and sign that portion of the form.

3. The completed and signed claim form must be returned to the policyholder who in turn should forward it to us, or to us. The completed and signed claim form must be provided within 90 days after the date of loss, but no later than one year after the date of the loss.

Examination

We sometimes require that a person be examined by a physician of our choice. These examinations will be at our expense. We will not require more than a reasonable number of examinations.

Beneficiary

At least one beneficiary must be designated on your EPIC application when you apply for coverage under the policy. Your beneficiary under your accidental death and dismemberment coverage need not be the same as your beneficiary under your term life coverage. You can not assign the right to designate a beneficiary to a third party.

You may change a beneficiary at any time by sending us a written request for the change. The written request for change must be sent to our office. No change will become effective unless we receive the request. Any beneficiary change will then be effective on the date you signed the request, unless otherwise specified in the request. If you die before we receive the request, the change will remain effective. If proceeds have been paid prior to our receiving the request at our office, our obligations under the policy will have been met and we will not be obligated to alter or change the payment.

If you name more than one beneficiary, available benefits, if any, will be divided equally among any surviving beneficiaries, unless otherwise requested by you in your beneficiary designation.

If any beneficiary dies prior to the end of a 15-day period after the date of your death, and proof of claim has not been received by us at our office, payment of available benefits, if any, will be made as if you had survived the beneficiary, unless otherwise requested by you in your beneficiary designation.

If your coverage(s) is reinstated in accordance with the provisions of the policy, the beneficiary shall be the beneficiary of record as of the date of the end of such reinstated coverage(s) unless your written notice of a subsequent beneficiary change has been filed and recorded with us under the policy.

Facility of Payment

If any benefits are payable to a person who is under the age of 18 years or to a person who is not legally competent to execute a valid receipt, then our payment of benefits is made to: (1) that person's duly-appointed guardian; or (2) if no guardian has been appointed, to another legal representative of that person; or (3) an individual who has, in our opinion, assumed the main care and support of your beneficiary.

Any benefits we pay under this provision will fully discharge us from all further liability to the extent of the benefits paid.

Claim Review Procedures

If a member or beneficiary does not agree with the denial of his/her claim, we will review our decision in accordance with the following procedure:

1. He/she must file a written appeal and mail it to:

The EPIC Life Insurance Company
Attention: Life & Disability Department
P.O. Box 8430
Madison, Wisconsin 53708-8430

The member or beneficiary must state the specific reasons why he/she does not agree with the denial. We cannot accept telephone requests for review.

2. Upon request, and at no charge, the member or beneficiary may obtain reasonable access to, and copies of, all documents, records and information relevant to his/her claim for benefits.

3. Our review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents and records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review on appeal will be a "fresh" look at the claim without deference to the denial decision. It will be conducted by a person or committee not involved in the denial decision and who is not a subordinate of, or the members of which are not subordinates of EPIC's supervisory or managerial employee involved in the denial decision.

If the member's benefit denial was based in whole or in part on a medical judgement, we will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved with the denial decision, nor be a subordinate of the health care professional who was involved. If we have obtained or will obtain medical or vocational experts in connection with the claim, they will be identified upon the member's or beneficiary's request, regardless of whether we rely on their advice in making any benefit determinations.

4. Within 60 days after we receive the member's or beneficiary's written request for review, we will send the member or beneficiary a written decision which will contain the specific reasons for our decision and identify the specific policy provisions on which the decision is based.

5. In some situations, we may need additional time to make a decision. In that case, before the 60-day period has expired, we will send the member or beneficiary a written notice that more time is necessary. Then we have up to an additional 60 days after the first 60-day period has expired (a total of 120 days from the date we received the member's or beneficiary's request for review) to provide the member or beneficiary with our decision.

Claim Processing Procedure

Following receipt of a correctly filed claim we will advise the member or beneficiary of our decision within 90 days of receiving the claim. A correctly filed claim includes: (1) notarized copy of the death certificate; and (2) completed claim form. Under certain circumstances we may need additional information such as accident or injury related - copies of police report, autopsy report, toxicology report, newspaper article(s) or obituary. We determine that the 90-day period begins the date we are in receipt of all completed statements. Any benefits paid under the policy shall fully discharge us from all further liability, to the extent of

benefits paid. If benefits are payable under the policy, payment of such benefits shall be made directly to the member or beneficiary.

In the event of an incomplete claim or circumstances beyond our control, we will advise the member or beneficiary that a 90-day extension is necessary. An incomplete claim is a correctly filed claim that requires additional information such as additional clinical documentation. In the event an extension is required, we will notify the member or beneficiary in writing of the reasons for the extension.

If the claim is denied, the member or beneficiary will receive a written notice from us with: (1) the specific reasons for the denial; (2) the specific references to the policy provisions on which the denial is based; (3) a description of additional material or information which may be necessary for the member or beneficiary to perfect his/her claim and an explanation of why such material or information is necessary; and (4) an explanation of how the member or beneficiary may have the claim reviewed by us if he/she does not agree with the denial or partial denial.

STANDARD PROVISIONS

Entire Contract

The entire contract between the policyholder and EPIC is made up of the policy, including the policyholder's group application, the policyholder's supplemental applications, if any, the certificate, Schedule of Benefits, all endorsements, if any, your application, and your supplemental applications, if any.

Waiver and Change

Only the president of EPIC can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. At our option, EPIC may unilaterally change any term, condition, exclusion, limitation or other provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under the policy, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect. Any change to the policy shall be made by endorsement which is signed by the president of EPIC. Each endorsement shall be binding on the policyholder, each of its members, and EPIC. No error by EPIC, the policyholder, or any member shall invalidate coverage otherwise validly in force, continue or reissue coverage validly terminated, or cause coverage to be issued which otherwise would not be issued by EPIC. Upon our discovery of any error, an equitable adjustment of coverage, payment of benefits, and/or premium shall be made by EPIC at its sole option.

Limitation on Lawsuits and Legal Proceedings

No member shall bring any legal action against us regarding payment of benefits, claims submitted, or any other matter concerning his/her coverage under the policy until the earlier of: (1) 60 days after we've received or waived proof of loss described in section "Payment of Claims" for which that legal action is brought; or (2) the date we deny payment of benefits for the claim for which that legal action is brought. Legal action can be brought earlier by that member only if waiting will result in prejudice against that member. However, the mere fact that a member has to wait until the earlier of the above two dates is not considered prejudicial. No legal action can be brought more than six years after the time we require written proof of claim to be timely submitted to us under the policy. Please see section "Payment of Claims".

Assignment

You may assign any right or interest you have under the policy. Such rights or interests include, but are not limited to, a change of beneficiary or mode of payment in accordance with the policy.

Relative rights of assignee and beneficiary, the rights of a beneficiary under a life insurance policy are subordinate to those of an assignee, unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

We will not be charged with notice of any assignment until such assignment is actually received by us and filed at our office. We shall assume no responsibility for the validity or effect of any assignment.

Right to Autopsy

Where not forbidden by law, we have the right to have an autopsy performed on any member's body who dies while covered under the policy. Such autopsies will be at our expense.

Suicide

If a member commits suicide within two years from his/her effective date of coverage under the policy, no proceeds are payable on that member's death under any coverage that he/she had under the policy. We will return the total premium(s) paid to us for that participant's coverage(s) under the policy during that period, to the person or entity who paid the premiums. If the member is an initial enrollee as defined in the policy, we will shorten the two year waiting period stated above by the number of days he/she was continuously covered under the policyholder's immediately prior life certificate of coverage.

Conformity with Laws of the State

On the effective date of the policy, any term, condition, or provision conflicting with the laws of the state applying to the policy automatically conforms with the minimum requirements of such laws.

General Right of Recovery

If we pay any monies or benefits that are not due or payable under the policy, including, but not limited to, benefits paid in error by us, we have the right to be repaid to the full extent of such overpayment. We shall be repaid to the full extent of such overpayment. We can recover such excess payments from any person, organization or institution to, for, or with respect to whom such monies were paid by us, including any member. If we cannot recover such excess payments from any other source, we can recover them from you or any of your dependents. When we request that you pay us an amount of the excess payments, you agree to pay us such amount immediately upon our notification to you. We may, at our option, reduce any future payments for which we are liable under the policy by the amount of the excess payments, in order to recover such payments. We will reduce such benefits otherwise payable until the excess payments are recovered by us. Our rights of recovery under this subsection are in addition to any rights we have under common law with respect to such overpayment.

Misstatement of Age

Age means a member's age on his/her last birthday. If any member's age has been misstated, the premiums for that person shall be equitably adjusted as determined by us. If the amount of coverage and/or payment of benefits for the member would be affected by such misstatement of age, the amount of coverage and/or payment of benefits shall be adjusted to that to which the member would have been entitled at his/her correct age and the premium shall be adjusted based on such adjusted amount of coverage.

Policyholder as Members' Representative

For any and all purposes regarding this policy, including each member's coverage provided under this policy, the policyholder is not the agent nor representative of EPIC. The policyholder represents only itself and its members insured under this policy. The policyholder, its members, employees, agents and representatives do not represent EPIC, our agents and representatives. The policyholder's agents and representatives are not our agents or representatives and do not represent EPIC, our agents and representatives. EPIC, our agents and representatives are not liable or responsible in any way whatsoever for any act, omission or

statement by the policyholder, its members, employees, agents and representatives. In addition, EPIC, our agents and representatives are not agents or representatives of the policyholder, any member insured under the policy or any other person.

Changing Classification

Any change in your classification with the policyholder, as indicated on the policyholder's current Employer Group Application, which results in any change of any coverage under the policy will take effect on the first day of the calendar month coinciding with or next following the date we receive notice of the change, provided you are actively at work with the policyholder on that day. If you are not actively at work, the following will apply:

1. if the change involves an increase in coverage, the change will not take effect until the day you again are actively at work with the policyholder; or

2. if the change involves a decrease in coverage, the change will take effect on the day of the change.

The policyholder is responsible for notifying us of any coverage changes, class or amount by completing the applicable EPIC change form and giving that completed change form to us within 30 days of the change.

Increasing the Amount of Voluntary Group Term Life and Voluntary Group AD&D Coverage

You may request an increase in the amount of voluntary term life coverage and voluntary AD&D coverage, at any time, if you currently have such coverage.

1. Definitions.

The following definitions apply to this subsection.

Guaranteed Issue Amount: the maximum dollar amount of coverage, as stated in the policy, we can guarantee issue without you and your dependents, if any, having to submit evidence of insurability to us. This amount is subject to all terms, conditions and provisions of the policy.

Maximum Coverage Amount: the maximum amount of coverage that we will offer you and your eligible dependents, if any.

2. When You Request An Increase in Coverage for Yourself.

a. The following conditions will apply if you request an increase in the amount of voluntary term life coverage and voluntary AD&D coverage within 31-days of the policy renewal date with us:

(1) you must be actively at work with the policyholder on the date of the increase:

(2) you must be under the age 70;

(3) the amount of each increase will be no greater than 10% of his/her current coverage rounded to the next $1,000, not to exceed the guaranteed issue amount stated in the policy;

(4) you cannot be eligible for waiver of premium paragraph 3. of subsection "Term Life Coverage";

(5) a claim cannot have been paid under the accelerated living benefit for the covered employee; and

(6) the last time an increase in coverage was requested, the you cannot have been declined by us.

If you request an increase in the amount of coverage greater than the guaranteed issue amount but not greater than the maximum coverage amount, you will be subject to our health underwriting requirements, including our approval of any evidence of insurability you may have to submit to us.

b. The following conditions will apply if you request an increase in the amount of coverage any time after the 31-day period immediately following the policy renewal date with us:

(1) you must meet the conditions described above in 2. a. (1), (2), (3), (4), (5) of this subsection; and

(2) you will be subject to our health underwriting requirements, including our approval of any evidence of insurability you may need to submit to us.

3. When You Request An Increase in Coverage for Your Covered Spouse.

a. The following conditions will apply if you request an increase in the amount of coverage for your covered spouse within the 31-day period immediately following the policy renewal date with us:

(1) you must be actively at work with the policyholder on the date of the increase:

(2) the covered spouse must be under the age 70;

(3) the amount of each increase will be no greater than 10% of his/her current coverage rounded to the next $1,000, not to exceed the guaranteed issue amount stated in the policy;

(4) you cannot be eligible for waiver of premium under paragraph 3. of subsection "Term Life Coverage";

(5) a claim cannot have been paid under the accelerated living benefit for the covered spouse; and

(6) the last time a change in coverage was requested the covered spouse cannot have been declined by us.

If you request an increase in the amount of coverage greater than the guaranteed issue amount but not greater than the maximum coverage amount, your covered spouse will be subject to our health underwriting requirements, including our approval of any evidence of insurability he/she may have to submit to us.

b. The following conditions will apply if you request an increase in the amount of coverage for your covered spouse any time after the 31-day period immediately following the policy renewal date with us:

(1) the conditions described above in 3. a. (1), (2), (3), (4), (5) of this subsection must be met; and

(2) the covered spouse will be subject to our health underwriting requirements, including our approval of any evidence of insurability he/she may need to submit to us.

Any increase in coverage under the policy will take effect on the first day of the calendar month coinciding with or next following the date we receive notice of the change, provided you are actively at work.

Requesting Previously Waived Coverage

An eligible employee and his/her eligible dependents, if any, may request coverage under the policy, if he/she had previously waived the coverage on their employee group application.

1. When You Request Additional Coverage For Yourself.

The following conditions will apply if you request one or more of the following: (a) term life coverage; (b) supplemental term life coverage; (c) voluntary term life coverage; (d) accidental death and dismemberment (AD&D) coverage; (e) supplemental (AD&D) coverage; (f) voluntary AD&D coverage any time after the 31-day period immediately following your initial date of eligibility as determined by us:

(1) you must be actively at work with the policyholder on the date of the request;

(2) you must be under the age 70;

(3) you cannot be eligible for waiver of premium under paragraph 3. of subsection "Term Life Coverage";

(4) you will be subject to our health underwriting requirements, including our approval of any evidence of insurability you may need to submit to us.

2. When You Request Additional Coverage for Your Depedents.

The following conditions will apply if you request term life coverage or voluntary term life coverage for your eligible spouse any time after the 31-day period immediately following the spouse's initial date of eligibility as determined by us:

(1) you must be a covered under the policy;

(2) you must be actively at work with the policyholder on the date of the request;

(3) the eligible spouse must be under the age 70;

(4) you cannot be eligible for waiver of premium under paragraph 3. of subsection "Term Life Coverage";

(5) the eligible spouse will be subject to our health underwriting requirements, including our approval of any evidence of insurability he/she may need to submit to us.

Any additional coverage under the policy will take effect on the first day of the calendar month coinciding with or next following the date of change, provided the insured is actively at work.

Conversion Privilege

1. Your Conversion Privilege.

If your term life coverage ends or the amount is reduced because your employment or membership in a class ends, you may apply for an individual conversion policy of whole life insurance (called a conversion policy) without giving information about your health. Issuance of a conversion policy is subject to the following conditions:

a. You may apply for the whole life conversion policy that we then make available to such a member who is converting his/her coverage under the policy prepared using sex-blended factors.

b. The face amount of your converted whole life insurance policy may not exceed the amount of your terminated term life coverage under the policy.

c. The premium for your conversion policy will be at our current applicable rate for that policy according to: (1) your class of risk; and (2) your age on the date the policy becomes effective.

d. You must submit written application and your first conversion premium to us within 31 days after your term life coverage ends under the policy.

If your term life coverage ends because of termination of the policy or termination of a class and you have been insured under the policy for the three years immediately prior to your coverage's termination date, you may apply within 31 days for a conversion policy. Issuance of the conversion policy is subject to conditions a. c. and d. above. The face amount of your converted whole life insurance policy may not exceed the amount of your terminated term life coverage under the policy less any amount for which you become eligible to purchase under any other group term life insurance policy within 31 days. You can not convert supplemental term life coverage or voluntary term life coverage, if any.

If you die within the 31-day period after your term life coverage ends, under the policy, we will pay a death benefit equal to the amount of term life coverage you were entitled to convert under the policy.

If we issue a conversion policy and you again become eligible and apply for term life coverage under the policy, your new term life coverage will become effective under the policy only if: (a) you terminate your conversion policy immediately; or (b) you submit, at your own expense, evidence of insurability satisfactory to us.

2. Conversion Privilege for Your Dependent.

If your covered dependent life coverage ends, your covered dependent may apply for an individual whole life conversion insurance policy without giving evidence of insurability if: (a) your covered dependent is no longer eligible; (b) the dependent's class terminates; (c) you die; or (d) under circumstances where you have the right of conversion under paragraph 1. above.

Issuance of a conversion policy is subject to the following conditions:

a. Your covered dependent may apply for the whole life conversion policy that we then make available to such a member who is converting his/her coverage under the policy prepared using sex-blended factors.

b. The face amount of your covered dependent's converted whole life insurance policy may not exceed the amount of his/her terminated dependent term life coverage under the policy.

c. The premium for your covered dependent's conversion policy will be at our current applicable rate for that policy according to: (1) his/her class of risk; and (2) his/her age on the date the policy becomes effective.

d. Your covered dependent must submit written application and his/her first conversion premium to us within 31 days after his/her dependent term life coverage ends under the policy.

If your covered dependent dies within the 31-day period after his/her dependent term life coverage ends under the policy, and he/she was eligible to convert under this provision, we will still pay a death benefit on that person's life. Upon receipt of proof of loss within one year after death, we will pay the amount for which the dependent was last insured. Your dependent can not convert voluntary term life coverage, if any.

If a conversion policy had been issued to the deceased dependent, we will pay benefits under this paragraph 2. only if the conversion policy is returned to us without any claim for benefits being made then or thereafter. We will refund all paid conversion premiums to you if the conversion policy is surrendered for this reason.

If we issue your dependent a conversion policy and he/she again becomes eligible and applies for term life coverage under the policy, his/her new term life coverage will become effective under the policy only if: (1) your dependent terminates the conversion policy; or (2) your dependent submits, at his/her own expense, evidence of insurability satisfactory to us.

THE EPIC LIFE INSURANCE COMPANY
DOMESTIC PARTNERSHIP ENDORSEMENT
FOR TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT CERTIFICATE

In consideration of the premiums charged by EPIC and paid by the group policyholder to EPIC for the coverages issued under the group insurance policy under which EPIC issued the EPIC Certificate of Insurance to which this endorsement is attached that certificate and group insurance policy are amended by EPIC as follows:

1. The following language is added to the subsection "Eligible Dependent (Dependent Life Coverage, if Applicable)" under section "ELIGIBILITY:"

(4) a covered employee's domestic partner provided all of the following conditions are met:

(a) the covered employee and his/her partner must be in a committed relationship (relationship of mutual support, caring and commitment and intend to remain in such a relationship in the immediate future);

(b) each partner must be 18 years of age or older and competent to contract;

(c) each partner must not be married or legally separated in marriage, and must not have been a party to an action or proceeding for divorce or annulment within six months of registration, or, if one has been married, at least six months have lapsed since the date of the judgment terminating the marriage;

(d) each partner must be competent to contract;

(e) neither partner is currently registered in another domestic partnership, and if either party has been in such a registered relationship, at least six months have lapsed since the effective date of termination of that registered relationship;

(f) a partner may be registered in only one such partnership at a time;

(g) there may be no blood ties closer than that permitted for marriage for one to qualify for domestic family partner registration;

(h) domestic family partners must live together to qualify for this benefit (i.e., occupy the same dwelling unit as a single non-profit housekeeping unit and have a relationship which is of permanent and domestic character);

(i) the relationship must not be merely temporary, social, political, commercial or economic in nature, i.e., there must be mutual financial interdependency;

(j) the covered employee must register his/her partner as a domestic partner with the Employer and EPIC providing proof that, for at least the six month period immediately preceding the date of registration, the covered employee either:

a. had obtained a domestic partnership certificate from the city, county or state of residence or from any other city, county or state offering the ability to register a domestic partnership; or

b. has any three of the following with respect to the domestic partner:

i. joint lease, mortgage or deed;

ii. joint ownership of a vehicle;

iii. joint ownership of checking account (demand deposit) or credit account;

iv. designation of the domestic partner as a beneficiary of the covered employee's will;

v. designation of the domestic partner as a beneficiary for the covered employee's life insurance or retirement benefits;

vi. designation of the partner as holding power of attorney for health care; or

vii. shared household expenses.

(5) the covered employee's domestic partner's child provided that:

(a) the domestic partner is a member under the policy;

(b) the domestic partner is the biological parent or has a court-appointed legal relationship with the child (i.e. adoption); and

(c) the child is unmarried and under the age shown in Section 3. a. of the Schedule of Benefits, or unmarried and under the age shown in Section 3. b. of the Schedule of Benefits, if he/she is a full-time student as determined by us.

2. The following paragraphs are added to section "WHEN DEPENDENT COVERAGE ENDS":

10. The date the domestic partner no longer meets the requirements stated in subsection "Eligible Dependent (Dependent Life Coverage , if Applicable)" under section "ELIGIBILITY:"

11. For a child of a domestic partner, the date the domestic partner's coverage ends under the policy.

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by EPIC. It shall continue in force under the same provisions as govern the policy.

All other terms, provisions and conditions of the entire policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company has executed this endorsement.

THE EPIC LIFE INSURANCE COMPANY

Michael F. Hamerlik

Michael F. Hamerlik, President

THE EPIC LIFE INSURANCE COMPANY

GROUP TERM LIFE CERTIFICATE OF INSURANCE

AMENDED BENEFITS ENDORSEMENT

In consideration of the premium charged for the group master policy under which EPIC Life issued the certificate to which this endorsement is attached, that certificate and policy are amended as follows:

A. The definition of "Full-Time Student" under Section "DEFINITIONS" is deleted and replaced by the following:

Full-Time Student: an adult child of a covered employee who meets all the following criteria:

1. the child is not married unless the child is under age 26; and

2. the child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; and

3. the child was under the age of 27 when called to federal active duty; and

4. within 12 months after returning from federal active duty, the child returned to an institution of higher education on a full-time basis, regardless of age.

The adult child must: (1) attend an accredited school for the number of credits, hours, or courses required by the school to be considered a full-time student; or (2) attend two or more accredited schools for credits toward a degree, which, when combined equals full-time status at one of the schools; or (3) participate in either an internship or student teaching during the last semester of school prior to graduation, if the internship or student teaching is required for his/her degree. The adult child continues to be a full-time student during periods of vacation or between term periods established by the school.

B. The subsection Eligible Dependent (Dependent Life Coverage, if Applicable) under the Section entitled "ELIGIBILITY" is deleted and replaced by the following:

Eligible Dependent (Dependent Life Coverage, if Applicable)

An eligible dependent is a person who is a citizen of the United States or a resident legal alien and who is:

1. a covered employee's lawful spouse;

2. a covered employee's natural child, adopted child, child placed for adoption with the covered employee, step-child or legal ward who is less than 26 years of age;

3. a covered employee's or covered employee's spouse's child who is a full-time student as defined in the policy; and

4. an unmarried natural child of a dependent child (as described in 2. above) until the dependent child is 18 years of age.

In the case of a child placed for adoption with the covered employee, the meaning of "placed for adoption" is defined in Section 632.896, Wisconsin Statutes, as amended.

A person is not an eligible dependent if he/she is:

1. covered under the policy as a covered employee;

2. on active duty with the military service, including national guard or reserves, other than for duty of less than 30 days; or

3. in the case of a child, if such child is no longer eligible if adopted or placed for adoption and insured under the adopting person's coverage in accordance with Section 632.896, Wisconsin Statutes, as amended.

No person shall be considered as an eligible dependent of more than one employee insured as a covered employee under the policy.

An unmarried dependent child who is over the age of 26 may remain insured as a dependent under the policy if he/she meets certain requirements, provided the covered employee's family coverage remains in force under the policy. The child must:

1. be unable to support himself/herself with a job because of mental retardation or physical handicap;

2. have become totally disabled before he/she reaches the age of 26; and

3. be principally supported by the covered employee.

Written proof of the child's totally disabling condition must be given to us within 31 days of the child attaining age 26. Failure to provide such proof to us within that 31-day period shall result in the termination of that dependent child's coverage in accordance with Section VII. WHEN DEPENDENT COVERAGE ENDS.

C. Section "WHEN DEPENDENT COVERAGE ENDS" is deleted and replaced by the following:

WHEN DEPENDENT COVERAGE ENDS

If applicable, your dependent's coverage will end under the policy at midnight central standard time at the main office of the policyholder on the earliest of the following dates:

1. the day he/she ceases to be a dependent as defined in the policy;

2. the date of a valid decree of divorce or annulment with respect to the dependent spouse;

3. the day your coverage ends;

4. the day immediately following the last day of the calendar month for which any premium for your dependent term life coverage is due and unpaid;

5. the day immediately following the last day of the calendar month in which we receive a request that the dependent term life coverage terminates;

6. the day the policy ends;

7. the day you resign, retire or die;

8. the day he/she dies; or

9. the date he/she enters into the military service other than for duty of less than 30 days.

10. For a dependent child who is a member, the earliest of the following dates, as determined by us:

a. The day immediately following the last day of the calendar month in which the child reaches age 26, provided he/she is not a full-time student as defined in this policy;

b. For step-children, the date the covered employee's spouse is no longer married to the covered employee.

11. For a child of a dependent child who is a member, the date the dependent child reaches age 18.

A full-time student who attains the limiting age while covered under the policy will remain eligible for coverage until the day immediately following the last day of the calendar month in which the child ceases to be a full-time student as defined in this policy.

If a dependent has attained the limiting age while covered under the policy and continues coverage as a full-time student, he/she may continue coverage if he/she ceases to be a full-time student due to a medically necessary leave of absence. In order to continue coverage, we must receive written documentation and certification of the medical necessity of the leave of absence from his/her attending physician. The date on which he/she ceases to be a full-time student due to the medically necessary leave of absence shall be the date on which coverage continuation begins.

Coverage shall continue for that full-time student until the earliest of the following dates:

1. The date the full-time student marries, unless he/she is under age 26;

2. The date coverage of the insured through whom the full-time student has dependent coverage under the policy is discontinued or not renewed; or

3. One year following the date the full-time student's continuation coverage began and he/she has not returned to school on a full-time basis.

If you have family coverage under the policy, a dependent child who is a mentally retarded or physically handicapped may continue coverage under your family coverage beyond the limiting age as set forth in Section II. B. Eligible Dependent.

It is the covered employee's responsibility to notify us of his/her child losing dependent status. If he/she does not so notify us, the covered employee shall be responsible for any claim payments made during the period of time the dependent was not eligible for coverage under the policy.

D. Paragraph 2. of subsection Term Life Coverage under the Section entitled "BENEFITS" is deleted and replaced by the following:

2. Dependent Benefits.

Subject to all terms, conditions and provisions of the policy, the coverage described in this paragraph 2. applies only if shown as being applicable in Section 3. a. of the Schedule of Benefits.

If an insured dependent dies while covered for term life coverage under the policy, we will pay benefits in the amount of coverage in force on that insured dependent at the time of his/her death:

a. to you, if living; or

b. to your estate,

if we receive satisfactory notice of a claim, the completed claim form, and all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records, accident reports, autopsy results, and other reports.

Benefits are paid in a lump sum. However, other arrangements for a different mode of payment may be made, subject to our prior written approval.

The benefit payable for dependent term life coverage is the amount equal to:

a. the base dependent term life amount shown in the policyholder's most current application for coverage; or

b. the voluntary dependent term life amount shown in your most current application for coverage and approved by us; plus

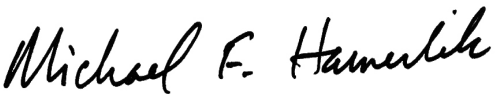
c. the supplemental dependent term life amount, if applicable, shown in your most current application for coverage and approved by us.

The amounts stated above are subject to any reductions shown in Section 3. b. and 3. c. of the Schedule of Benefits. If an age reduction applies, the benefit reduces on the date the dependent becomes that age.

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by The EPIC Life Insurance Company. It shall continue in force under the same provisions as govern the policy. All other terms, provisions and conditions of the entire policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company executed this endorsement.

The EPIC Life Insurance Company



Michael F. Hamerlik, President

THE EPIC LIFE INSURANCE COMPANY
AMENDED BENEFIT ENDORSEMENT
FOR TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT CERTIFICATE

In consideration of the premiums charged by EPIC and paid by the group policyholder to EPIC for the coverages issued under the group insurance policy under which EPIC issued the EPIC Certificate of Insurance to which this endorsement is attached that certificate and group insurance policy are amended by EPIC as follows:

1. The following is deleted from the Section entitled "Conversion Privilege" under Subsection "1. Your Conversion Privilege."

You can not convert supplemental term life coverage or voluntary term life coverage, if any.

2. The following is deleted from the Section entitled "Conversion Privilege" under Subsection "2. Conversion Privilege for Your Dependent."

Your dependent can not convert voluntary term life coverage, if any.

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by EPIC. It shall continue in force under the same provisions as govern the policy.

All other terms, provisions and conditions of the entire policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company has executed this endorsement.

THE EPIC LIFE INSURANCE COMPANY

Michael F. Hamerlik

Michael F. Hamerlik, President

THE EPIC LIFE INSURANCE COMPANY

AMENDED BENEFITS ENDORSEMENT FOR

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT CERTIFICATE

In consideration of the premium charged for the Group Policy under which EPIC issued the Certificate to which this endorsement is attached, that Certificate and the Group Policy is amended as follows.

In Section "DEFINITIONS" the following definition is added:

Adverse Benefit Determination: any denial, reduction, retroactive recission, or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

In Section "PAYMENT OF CLAIMS" subsection "How to File Claims", "Claim Review Procedures" and "Claim Processing Procedure" are deleted.

In Section "PAYMENT OF CLAIMS" the following subsections are added:

How to File Claims

It is important that the member or the beneficiary notify us as soon as possible so that a claim decision can be made in a timely manner. Before a claim can be considered, the member, or the beneficiary, must give us written proof of claim.

Benefits payable under the policy will be paid as soon as reasonably possible after we receive the written proof of claim required in accordance with "Proof of Claim" below.

Authorized Representatives

A member may designate an authorized representative to act on his/her behalf in pursuing a benefit claim or appeal. The authorization must be made in writing to EPIC on a form approved by us. An assignment of benefits does not constitute a designation of an authorized representative.

Claim Processing Procedure

Following receipt of a written proof of claim, we will advise the member or beneficiary of our decision within a reasonable period of time, but no later than 45 days after receiving proof of claim.

This period may be extended by an additional 30 days, if we determine the extension is necessary. Before the end of the initial 45-day period, we will send notification of the extension to indicate the circumstances requiring the extension and the date by which we expect to make a decision.

The review period may be extended for another 30 days, if before the end of the first 30-day extension, we determine a second extension is necessary. Before the end of the first 30-day extension, we will send notification of the additional extension to indicate the circumstances requiring the extension and the date by which we expect to make a decision.

31659-088-1801

For use with E12074IA-0708, E12074FL-0708, E12074OK-0708, E12074IN-0708, E12074KY-0708, E12074ND-0708, E12074SD-0708, E12074WI-0708, E12074WV-0708 and 31796-088-1801-Missouri

If the reason for the extension is because we do not have enough information to decide the claim, then the notice of extension will describe the required information and the member or the beneficiary will have at least 45 days from the date the notice is received to provide the specified information. We will make a decision on the earlier of the date on which the member or the beneficiary responds or the expiration of the time allowed for submission of the requested information.

Any benefits paid under the Policy shall fully discharge us from all further liability, to the extent of benefits paid. If benefits are payable under the Policy, payment of such benefits shall be made directly to the member or beneficiary.

If the claim is denied, the member or beneficiary will receive a written notice of denial with: (1) the specific reasons for the denial; (2) the specific references to the policy provisions on which the denial is based; (3) a description of additional material or information which may be necessary for the member or beneficiary to perfect his/her claim and an explanation of why such material or information is necessary; (4) a description of our review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review, if applicable, including a description of any applicable contractual limitations period, and the calendar date on which the contractual limitations period expires, for the claim that applies to a claimant's right to bring such an action; (5) an explanation of the basis for disagreeing with any disability determination made by: (a) the member's treating physician, (b) any medical or vocational expert whose advice was obtained on behalf of EPIC in evaluating the claim, or (c) the Social Security Administration, as applicable; and (6) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all, documents, records, and other information relevant to the claimant's claim for benefits.

If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also disclose if any internal plan rule, protocol, or similar criterion was relied upon to deny the claim. A copy of the rule, protocol, or other similar criterion will be provided, free of charge, to the member or beneficiary upon request. Alternatively, if no such internal rules, protocol, or similar criterion exist, then the notice will include a statement indicating that none exist. Lastly, the notice will be provided in a culturally and linguistically appropriate manner.

If the member, or the beneficiary, want to appeal the denial, such an appeal must be made in accordance with subsection "Claim Review Procedures" below.

Claim Review Procedures

If a member or beneficiary does not agree with the denial of a claim, we will review our decision in accordance with the following procedure:

1. He/she must file a written appeal to EPIC within 180 days following receipt of a benefit denial notification. Such written appeal should be mailed to:

The EPIC Life Insurance Company
Attention: Claims Department
P.O. Box 8430
Madison, Wisconsin 53708-8430

The member or beneficiary must state the specific reasons why he/she does not agree with the denial. We cannot accept telephone requests for review.

2. Upon request, and at no charge, the member or beneficiary may obtain reasonable access to, and copies of, all documents, records, and information relevant to his/her claim for benefits.

3. Our review will take into account all comments, documents, records, and other information submitted that relates to the claim. This would include comments, documents and records, and other information that either were not submitted previously or were not considered in the initial benefit decision.

The review on appeal will be a fresh look at the claim without deference to the denial decision. It will be conducted by a person or committee not involved in the denial decision and who is not a subordinate of the EPIC employee involved in the initial denial decision.

If the member's benefit denial was based in whole or in part on a medical judgment, we will consult with a health care professional with training and experience in the relevant medical field. This health care professional engaged for purposes of consultation shall be an individual who is neither an individual who was consulted in connection with the initial denial decision that is subject of the appeal, nor the subordinate of any such individual. If we have obtained or will obtain medical or vocational experts in connection with the claim, they will be identified upon the member's or beneficiary's request, regardless of whether we rely on their advice in making any benefit determinations.

4. We will provide, free of charge, a copy of any new or additional evidence considered, relied upon, or generated in connection with the review of your claim. We will provide this information as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination on review is required to be provided in order to provide a reasonable opportunity to respond.

5. We will provide, free of charge, a copy of any new or additional rationale considered or relied upon in connection with the review of the claim. We will provide this information as soon as possible and sufficiently in advance of the date on which a notice of adverse benefit determination on review is required to be provided in order to provide a reasonable opportunity to respond.

6. Within 45 days after we receive the member's or beneficiary's written request for review, we will send the member or beneficiary a written decision. If the initial denial decision is upheld, then the written notice will contain:

a. The specific reasons for our denial decision;

b. A reference to the specific policy provisions on which the denial decision is based;

c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

d. A statement of the claimant's right to bring a civil action under ERISA section 502(a), if applicable, including a description of any applicable contractual limitations period, and the calendar date on which the contractual limitations period expires, for the claim that applies to a claimant's right to bring such an action.

e. An explanation of the basis for disagreeing with any disability determination made by the: (1) claimant's treating physician, (2) any medical or vocational expert whose advice was obtained on behalf of EPIC in evaluating the claim, or (3) the Social Security Administration, if applicable.

f. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also disclose if any internal plan rule, protocol, or similar criterion was relied upon to deny the claim. A copy of the rule, protocol, or other similar criterion will be provided, free of charge, to the member or beneficiary upon request. Alternatively, if no such internal rules, protocol, or similar criterion exist, then the notice will include a statement indicating that none exist.

g. The notice will be provided in a culturally and linguistically appropriate manner.

7. In some situations, we may need additional time to make a decision. In that case, before the initial 45-day period has expired, we will send the member or beneficiary a written notice that more time is necessary, the reasons for the extension, and the date by which we expect to render a decision. In no event shall such extension exceed a period of 45 days from the end of the initial 45-day period (a total of 90 days from the date we received the member's or beneficiary's request for review) to provide the member or beneficiary with our decision.

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by EPIC. It shall continue in force under the same provisions as govern the Policy.

All other terms, provisions and conditions of the entire Policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company has executed this endorsement.

THE EPIC LIFE INSURANCE COMPANY

Michael F. Hamerlik

Michael F. Hamerlik, President

THE EPIC LIFE INSURANCE COMPANY

AMENDED BENEFITS ENDORSEMENT FOR

GROUP LIFE CERTIFICATE

In consideration of the premium charged for the Group Policy under which EPIC issued the Certificate to which this endorsement is attached, that Certificate and the Group Policy is amended as follows.

The following language will be added:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

EPIC Specialty Benefits
The EPIC Life Insurance Company
Customer Service
1717 West Broadway
P.O. Box 8430
Madison, Wisconsin 53708-8430
Toll Free: 1-800-520-5750

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

This endorsement shall be effective beginning with the date for which the appropriate premium shall have been paid to and accepted by EPIC. It shall continue in force under the same provisions as govern the Policy.

All other terms, provisions and conditions of the entire Policy remain unchanged except as stated above.

IN WITNESS WHEREOF, The EPIC Life Insurance Company has executed this endorsement.

THE EPIC LIFE INSURANCE COMPANY

Michael F. Hamerlik, President