Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 45132
Jacksonville, FL 32232-5132
Phone: (800) 333-3256

CERTIFICATE OF INSURANCE

Group Short Term Disability

Policyholder: CITY OF VENICE

Class: 002 - ALL ACTIVE, ELECTED OFFICIALS

State of Residence: FLORIDA

This is to certify that Florida Combined Life has issued and delivered the Group Short Term Disability Insurance Policy to the Policyholder.

The policy insures the employees of the policyholder who:

1. are eligible for the insurance;
2. become insured; and
3. continue to be insured;

according to the terms of the policy.

The terms of the policy that affect your insurance are contained in the following pages.

The employee shall be given a copy of the group enrollment application.

This Certificate of Insurance is a part of the policy. This certificate replaces any other that Florida Combined Life may have issued to the policyholder to give to you under the Group Insurance Policy specified herein.

Premiums may change in accordance with the Premium Provisions of the policy.

To present inquiries, obtain information about coverage, or get assistance to resolve a complaint, please call us at 1-(800) 333-3256. To receive claims assistance, please call us at 1-(800) 696-8562.

Signed for Florida Combined Life:

Secretary

President

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Schedule of Insurance

Policyholder:	CITY OF VENICE
Group Policy Number:	95029
Policy Effective Date:	January 1, 2015* *This certificate replaces any certificate issued before the date shown.
Eligible Class:	Class 002 - ALL ACTIVE, ELECTED OFFICIALS
Full-time Employment:	20 hours weekly
Renewal Date:	January 1, 2018

Waiting Period: You will be eligible for coverage on the first of the policy month following completion of the following period of continuous active work:

1. If you are working for the employer on the policy effective date – 0 days
2. If you start working for the employer after the policy effective date – 30 days

Benefits amounts for eligible employees shall be determined in accordance with the following schedule:

Benefit	Benefit Amount
Short Term Disability	60% of weekly earnings to a maximum of $1,200 per week. **Elimination Periods:** Accident – 29 days Sickness – 29 days **Benefit Begins:** Accident – Day 30 and Sickness – Day 30 **Maximum Benefit Period:** 9 weeks

If a covered person is eligible for any amount in excess of the guaranteed issue amount shown below, the employee must furnish evidence of insurability, which is subject to our approval.

Benefit	Guaranteed Issue Amount
Short Term Disability	$1,200

Definitions

The terms listed, if used, will have these meanings.

Accident or Injury mean accidental bodily injury sustained by the covered person while insured under the policy which is the direct cause of the loss, independent of disease or bodily infirmity or any other cause.

Active Work or Actively at Work mean the expenditure of time and energy for the policyholder or an associated company at your usual place of business on a full-time basis. If you are not working on a day your coverage would otherwise take effect, you will be considered to be at active work on that day only if:

1. when that work day begins, it would be reasonable to expect that you would be physically and mentally able to complete a full-time week of work in your regular occupation; and
2. you are not disabled; and
3. your contract of employment, if applicable, remains active; and
4. you are not on an unapproved, administrative or disciplinary leave; and
5. you return to work at the end of a paid break or vacation period.

Associated Company means any company shown in the application which is owned by or affiliated with the policyholder.

Contributory means you pay part of the premium.

Covered Person means an eligible employee whose insurance has become and remains effective under all the conditions and provisions of the policy. Covered persons do not include contract, temporary, seasonal, or part-time workers.

Date of Disability means the first day that you are under the regular care of a physician and meet the definition of disability as defined below.

Eligible Class means a class of persons eligible for insurance under the policy. This class is based on employment or membership in a group.

Eligible Persons means a person who:

1. is a citizen of the United States of America (U.S.) or Canada, who either:
   a. resides in the U.S. or Canada; or
   b. is stationed outside the U.S. or Canada for a period of less than 6 months; or
2. is a foreign national residing in the U.S. and meets all of the following requirements:
   a. has a valid permanent residency visa;
   b. participates in U.S. Social Security; and
   c. is covered by Workers' Compensation.

Elimination Period means the number of days during a period of disability that must pass before benefits are payable. No benefits are payable for the Elimination Period. You cannot satisfy any part of the elimination period with any period of non-covered disability. The elimination period is shown on the Schedule of Insurance and begins on the first day of your disability.

Employee means an eligible person who is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Employer means the policyholder.

Evidence of Insurability means a signed health and medical history form provided by us, a medical examination, if requested, and any additional information and attending physicians' statements that we may require.

Family Member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent, grandchild, step-child, step-parent, step-sister, step-brother, father-in-law, or mother-in-law of the covered person; or spouses, as applicable, of any of these.

Full-time means working at least the number of hours indicated in the Schedule of Insurance for Full-time employment.

Gender – The use of the male pronoun also includes the female.

Home Office means the principal office of Florida Combined Life in Jacksonville, Florida.

Hospital means a facility supervised by one or more physicians and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital Confined and Hospital Confinement means staying in a hospital as a registered inpatient for 24 hours a day.

Material and Substantial Duty or Material and Substantial Duties mean the sets of tasks or skills required generally by employers from those engaged in an occupation. We will consider one material and substantial duty of your regular occupation to be the ability to work for an employer on a full-time basis as defined in the policy.

Noncontributory means the policyholder pays the premium.

Occupation means a group of jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Partial Disability or Partially Disabled means that, due to your injury or sickness:

1. you are able to perform the material and substantial duties of your regular occupation or any other occupation on a less than full time basis; or
2. you are able to perform one or more, but not all, of the material and substantial duties of your regular occupation or any other occupation on a full-time or part-time basis; and
3. as a result of either 1 or 2 above, your current earnings are less than 80% of your covered pre-disability earnings.

If your professional or occupational license or your certification is suspended, revoked or surrendered, loss of your license or certification, by itself, does not mean you are disabled.

Physician means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom we are required to recognize as a physician by the laws or regulations of the governing jurisdiction. However, neither you nor a family member will be considered a physician.

Plan means the policy and certificates of insurance provided for covered persons.

Plan Administrator means the employer that sponsors the plan for the benefit of its employees and eligible dependents.

Policy means the group policy issued by us to the policyholder that describes the benefits for which you may be eligible.

Policyholder means the entity to which the policy is issued.

Regular Care means you personally visit a physician as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards; and you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a physician whose specialty or experience is appropriate.

Regular Occupation means the occupation in which you were working immediately prior to becoming disabled.

Retiree or Retirement means you begin receiving retirement benefits from either:

1. a retirement plan sponsored by your employer, the policyholder, or an associated company, or
2. a government plan.

Sickness means a disease or illness, including pregnancy.

Total Disability or Totally Disabled means an injury or sickness that requires you to be under the regular care of a physician and prevents you from performing the material and substantial duties of your regular occupation.

United States of America means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

Waiting Period is the number of continuous days of service during which you must be an active, full-time employee in a class eligible for insurance before you become eligible for coverage.

We, Us, and Our mean Florida Combined Life.

Weekly Earnings means your normal weekly rate of pay in effect on the day before you became disabled, excluding any overtime pay, bonuses, commissions, or any other extra pay.

You and Your mean an employee of the policyholder or an associated company who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the employer; and
2. paid for services by the employer; and
3. actively at work for the policyholder or an associated company; or
4. a retiree, if listed as eligible in the policy.

No director, officer, consultant or other person not actively at work on behalf of the employer will be considered an employee unless he meets the above conditions.

Eligibility and Effective Date Provisions

Eligible Employee

If you are working on a full-time basis for the employer, you are eligible for insurance after completion of the required waiting period, provided you are in a class of employees who are included.

Employee Eligibility Date

If you are working for your employer in an eligible class, the date you are eligible for coverage is the latest of the following dates:

1. the policy effective date;
2. the day after you complete any waiting period shown in the Schedule of Insurance by continuous service with the employer, the policyholder, or an associated company;
3. the date the policy is changed to include your class; or
4. the date you become a member of a class eligible for insurance.

Rehires: If you were insured under this policy and your insurance terminated due to termination of employment or eligibility, and you again become an eligible employee within 12 months, there is no waiting period.

Effective Date of Employee Insurance

You must use forms approved by us when applying for insurance.

For Benefit Amounts Not Requiring Evidence of Insurability:

1. When your Employer pays 100% of the cost of your coverage under the policy, you will be covered at 12:01 a.m. at your employer's address on your eligibility date.
2. When you and your Employer share the cost of your coverage under the policy or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at your employer's address on the latest of the following dates:
   a. on your eligibility date, if you enroll for insurance within 31 days after the date you first become eligible for coverage. If you do not apply for coverage during this period, you will be considered a late enrollee and will be required to submit satisfactory evidence of insurability; or
   b. on the first day of the policy month following the date we approve your application if you do not apply for insurance within 31 days after your eligibility date.

For Benefit Amounts Requiring Satisfactory Evidence of Insurability, your coverage will be effective on the first day of the policy month following the date we approve your application.

Delayed Effective Date

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, it will take effect on the day you return to active work. If your insurance is scheduled to take effect on a non-working day, your active work status will be based on the last working day before the scheduled effective date of your insurance.

Changes in Coverage Provisions

When Coverage Amounts Change (Redetermination Date)

The policy redetermines your amount of insurance on the date a change occurs. If benefits are based on your salary, the policyholder must report updates to all covered person's earnings as they occur. Changes to a covered person's earnings are subject to any proof of insurability requirements of the policy. As of the policy's redetermination date, we use a covered person's salary or earnings on record with us to: (a) set rates; (b) set benefit amounts and limits; and (c) calculate premium payable under the policy.

Delayed Effective Date of Change

You must be actively at work on a full-time basis on the redetermination date. If you are not, your coverage amount will not change until the date you return to active work on a full-time basis. Changes in salary or earnings will not apply to a recurring disability.

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

Changes to the Policy

Any increase or decrease in coverage because of a change in the plan of insurance will become effective on the date of the change. The Delayed Effective Date provision will apply to an increase.

Termination Provisions

Termination of Employee Insurance

Your insurance will terminate at 12:00 midnight on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date the policy terminates, or the date a specified benefit terminates;
3. the date you cease to be a member of a class eligible for insurance;
4. the date you cease to be actively at work;
5. if your coverage is continued under the Waiver of Premium provision, the date benefits cease to be payable.

Continuation of Insurance

If you are unable to perform active work for a reason shown below, the policyholder may continue your insurance on a premium-paying basis provided you remain in other respects a member of an eligible class. The continuation cannot be more than the maximum continuation shown below. The employer must act so as not to discriminate unfairly among employees in similar situations.

The maximum continuation for insurance is three months following the date active work stopped due to lay-off or approved leave of absence.

Total Disability for Continuation of Insurance means an injury or sickness that requires you to be under the regular care of a physician and prevents you from performing the material and substantial duties of your regular occupation.

Claim Provisions

Payment of Benefits

We will pay benefits at the end of each week (or shorter period) for which we are liable, after we receive the required proof. If any amount is unpaid when disability ends, we will pay it when we receive the required proof.

To Whom Payable

We will pay all benefits to you. However, if we receive proof that a legal guardian or conservator has been appointed, we will pay benefits to such guardian or conservator. If any amount remains unpaid when you die, we will pay at our discretion, to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate.

Authority

The policyholder delegates to us and agrees that we have the sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the policy.

We decide: (a) if a covered person is eligible for this insurance; (b) if a covered person meets the requirements for benefits to be paid; and (c) what benefits are to be paid by the policy. We also interpret how the policy is to be administered. What we pay and the terms for payment are explained in this certificate.

Filing a Claim

1. You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our Home Office. We need enough information to identify you as a covered person.
2. Within 15 days after the date of your notice, we will send you certain claim forms. The forms must be completed and sent to our Home Office. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.
3. The time limit for filing a claim, by submission of a completed claim form, is 90 days after the end of the first month (or shorter period) for which we are liable.
4. To decide our liability, we may require:
    a. proof of benefits from other sources, and
    b. proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

Proof of Loss

You must give us written proof that you are currently disabled and have been continuously disabled since your last day of active work. Proof must be given within 90 days after the end of your elimination period. If it was not reasonably possible to give written proof in the time required, the insurer shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

Continuing proof of disability must be given as often as we may reasonably require. Continuing proof must be given within 90 days of our request.

You must provide us with all of the information we specify as necessary to determine proof of loss and decide our liability. This may include but is not limited to: medical records; hospital records; pharmacy records; test results; therapy and office notes; mental health progress notes; medical exams and consultations; tax returns; business records; Workers' Compensation records; payroll and attendance records; job descriptions; Social Security award and denial notices; and Social Security earnings records.

You must provide us with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to us which enables us to decide our liability. If you do not provide us with continuing proof of disability and the items and authorization necessary to allow us to determine our liability, we will not pay benefits.

Right to Examine or Interview

We may ask you to be examined as often as we require at any time we choose. We may require you to be interviewed by our authorized representative. We will pay third party charges for any independent medical exam or interview which we require. If you fail to attend or fully participate, we will not pay your benefits.

Limit on Legal Action

No action at law or in equity may be brought against the policy until at least 60 days after you file written proof of loss. No action can be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the policy. We will also advise you of your further appeal rights, if any.

Subrogation and Right of Reimbursement

The plan assumes and is subrogated to your legal rights to recover any payments the plan makes for benefits, when a covered sickness or injury resulted from the action or fault of a third party. The plan's subrogation rights include the right to recover the amount of benefits paid to you.

The plan has the right to recover any and all amounts equal to the plan's payments from:

1. the insurance of the injured party;
2. the person, company (or combination thereof) that caused the sickness or injury, or any insurance company; or
3. any other source, including disability benefit coverage.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The plan's recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the plan's right of subrogation, the plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. You agree to reimburse the plan 100% first for any and all benefits provided through the plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

1. any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
2. any auto or recreational vehicle insurance coverage or benefits including, but not limited to disability benefit coverage; and
3. business and homeowner disability insurance coverage or payments.

The plan may notify those parties of its lien and right to reimbursement without notice to or consent from any covered person.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available disability insurance coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

You are required to notify us promptly if you are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable us to protect the plan's rights under this section. You are also required to cooperate with us and to execute any documents that we, acting on behalf of the policyholder, deem necessary to protect the plan's rights under this section.

You shall not do anything to hinder, delay, impede or jeopardize the plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the plan to withhold any and all benefits due you under the plan. This is in addition to any and all other rights that the plan has pursuant to the provisions of the plan's subrogation rights and/or priority right of reimbursement.

If the plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys' fees, the plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If a covered person settles any claim or action against any third party, that covered person shall be deemed to have been made whole by the settlement and the plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. The covered person shall hold any such proceeds of settlement or judgment in trust for the benefit of the plan. The plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the covered person in such circumstances.

Additionally, the plan has the right to sue on the covered person's behalf, against any person or entity considered responsible for any condition resulting in benefits paid or to be paid by the plan.

Settlement or Other Compromise

The covered person must notify the plan prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the plan's rights so that the plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against the covered person.

The right of subrogation and the right of reimbursement are based on the plan language in effect at the time of judgment, payment, or settlement.

The plan, or its representative, may enforce the subrogation and priority right of reimbursement.

Alternate Dispute Resolution Procedures

This dispute resolution procedure ("procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with us. Such disputes include any matters that cause you to be dissatisfied with any aspect of your relationship with us, including any claim, controversy, or potential cause of action you may have against us. Please contact the Dispute Resolution office at 1-800-333-3256 if you have any questions about this section of the certificate or to begin the dispute resolution process.

The following terms are applicable to all disputes:

1. This procedure is the exclusive method of resolving any disputes.
2. The procedure can only resolve disputes that are subject to our control.
3. This procedure will be governed by the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation"). That includes the definition of an adverse benefit determination, which is defined as any denial, reduction, termination or failure to provide or make payment for what you believe should be a covered benefit.
4. You may request a form from our Dispute Resolution office to authorize another person to act on your behalf concerning a dispute.
5. We may elect to skip one or more of the steps of this procedure if it is determined that step will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with the terms of this certificate, applicable state or Federal laws and regulations.
7. You must begin the dispute process within 180 days from the date you receive notice of an adverse benefit determination. If you do not initiate the dispute process within that 180 day period, you give up the right to take any action based on that Dispute.

Description of the Procedure

Inquiry

You should contact our Dispute Resolution office to discuss and attempt to resolve any issues regarding a dispute. We hope that this informal process will resolve your questions or concerns.

Appeals

If you are not satisfied with the response to your inquiry, you may submit a written request (an "appeal") to the Office of the Appeals Coordinator, Florida Combined Life, P.O. Box 1650, Little Rock, AR 72203-1650, asking that we reconsider an adverse benefit determination. Please contact the Dispute Resolution office if you have any questions about how to submit an appeal to us. You are not required to use a specific form, but you may request that the Dispute Resolution office send you a blank appeal form to ensure that you provide the information that will be needed to review your appeal.

We will assign a coordinator to review your appeal. The appeal coordinator is an individual with appropriate expertise who is neither the individual who made the adverse benefit determination, nor a subordinate of that individual.

The appeal coordinator may request that you submit additional information concerning your grievance. The appeal coordinator will also consider information submitted by others, including information requested from other Florida Combined Life representatives. The appeal coordinator will have full discretionary authority to make eligibility, benefit or claim determinations and construe the terms of the policy. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the policy is not governed by ERISA.

We will make a decision within 60 days after receiving your appeal concerning a claim determination.

The appeal coordinator will send you a written decision concerning your appeal. The appeal coordinator's decision will include: a statement of the coordinator's understanding of your appeal; a statement explaining the basis of the decision; and a list of the documents or information upon which that decision was based. We will send you a copy of the listed documents, without charge, if you make a written request for such documents.

Post Appeal Procedure

If you are still not satisfied after completing the appeal procedure, you have the right to bring a civil action against us to obtain the remedies available pursuant to Sec. 502(a) of ERISA (an "ERISA Action") after completing the mandatory appeal process. Those ERISA remedies will apply to this policy even if your plan is not otherwise governed by ERISA. If both parties agree to voluntary, non-binding arbitration of a dispute, we agree to suspend (or toll) any time periods affecting your right to bring an ERISA Action against us related to that dispute, until the arbitration has been completed.

You may request that the dispute be submitted for resolution by arbitration. That arbitration request must be submitted, in writing, to Florida Combined Life's General Counsel within sixty (60) days after you receive the appeal coordinator's decision.

The dispute will be submitted to arbitration in accordance with the rules of the American Arbitration Association, unless we both agree to use an alternative dispute resolution administrator or procedure. The arbitration will be conducted before a single arbitrator.

We will pay the filing fee charged by the administrator and the arbitrator. You will be solely responsible for any other costs that you incur to participate in the arbitration process, including your attorney's fees. The filing fee and arbitrator's fees may be reallocated as part of an arbitration award, in whole or in part, at the discretion of the arbitrator.

The arbitration will be conducted in the jurisdiction of your residence and at a location where it is reasonably convenient for you to participate. If we cannot agree concerning a convenient location, the administrator or arbitrator, if appointed, shall have the discretion to decide where the arbitration will be conducted.

The arbitrator: (a) shall consider the dispute individually and shall not certify or consider multiple disputes as part of a class action; (b) shall be required to issue a reasoned written decision explaining the basis of his or her decision and the manner of calculating any award; (c) shall limit his or her decision to deciding if our adverse benefit decision was arbitrary or capricious based on ERISA standards; (d) may not award punitive, extra-contractual, treble or exemplary damages unless permitted to do so by applicable statutes or regulations; (e) may not vary or disregard the terms of the policy; and (f) shall be bound by controlling law; when issuing a decision concerning the dispute.

The arbitrator shall limit discovery to the extent possible consistent with the objective of completing the arbitration in a fair, prompt, and cost effective manner. Emergency relief such as injunctive relief may be awarded by the arbitrator.

Contact Information

General Counsel
Florida Combined Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: 1-800-333-3256

Office of the Dispute Resolution Coordinator
Florida Combined Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: 1-800-333-3256

Office of the Appeal Coordinator
Florida Combined Life
P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: 1-800-333-3256

General Provisions

Entire Contract

This certificate is furnished in accordance with and subject to the terms of the policy. The entire contract consists of the policy, which includes the application, any amendments and addenda; this certificate; your enrollment form, if required; and any riders or endorsements. No change in the policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to the policy. No agent has authority to change the policy or certificate or to waive any of their provisions.

Any statement made by you or the policyholder is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the policyholder's plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Incontestability

Unless the premiums have not been paid, the validity of the policy cannot be contested after it has been in force for two years.

Any statement made by the policyholder or a covered person will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the covered person or the beneficiary.

No statement made by a covered person about insurability will be used to deny a claim for a loss incurred or disability starting after coverage has been in effect for two years.

No claim for loss starting two or more years after the covered person's effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Agency

Neither the policyholder, any employer, any associated company, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Unpaid Premium

We may deduct any unpaid premium then due from the payment of a claim under this certificate.

Refund of Premium

On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the date of death. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished to us.

Conformity with State Statutes

If the provisions of this certificate do not conform with the laws of the state in which you reside on the certificate effective date, they are hereby amended to conform with the minimum requirements of the statutes of that state.

Policy Management

Efficient management of the policy requires the joint efforts of the policyholder, Florida Combined Life, and each covered person. Each party has certain duties to bring about the effective administration of the policy.

Duties of the Policyholder: The policyholder's primary duties under the policy are listed below.

1. Give us prompt, written notice of any change in business of the policyholder and employer. This includes, but is not limited to: (a) the type of business; (b) addition or deletion of an associated company; or (c) financial status due to bankruptcy; merger; acquisition; or dissolution.
2. Give us pertinent records for all covered persons. This includes, but is not limited to: (a) hire dates; (b) eligibility dates; (c) salaries; (d) occupations; and (e) birth dates. Give us updates of such records as needed.
3. In order to start case management, give us prompt notice of a covered person's disability. This notice should be given as soon as possible after the date of injury or start of sickness. The most effective time for such notice is when the covered person has not been able to perform active work for 30 days.
4. In order to support case management, give us occupational data for all disabled covered persons. This includes, but is not limited to: (a) job descriptions and analyses; and (b) environmental factors.

Duties of Covered Persons: Your primary duties under the policy are listed below.

1. Give notice of claim as soon as possible after the date of your injury or the start of your sickness. Prompt notice will permit us to start case management.
2. Give a complete account of the details of your sickness or injury. This will include: (a) the cause of your disability, if known; (b) a description of your sickness or the accident that caused your injury; and (c) a list of all physicians, hospitals, or other facilities where you have been treated for the cause of your disability.
3. Allow release of medical and/or income data needed to assess your claim.
4. Give periodic medical updates as required by the policy.
5. Take part in any medical, financial or vocational assessment as required by the policy.
6. Apply for other income benefits to which you may be entitled.
7. Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.
8. Promptly report to us changes in your personal status. This includes: (a) change of address or phone number; (b) changes in how your disability affects your daily living; and (c) changes in your level of social, volunteer or business activities.
9. If we overpay benefits, promptly report and repay any amount overpaid.
10. If you are working while disabled, promptly report to us the amount of your income for such work.

11. Give us proof of your earnings for the period prior to your disability and while you are disabled.

Fraud

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

Short Term Disability Benefits

Weekly Benefit

We will pay the weekly benefit as determined in the Weekly Benefit Calculations provision, if you become disabled while insured and are under the regular care of a physician due to sickness or injury. We will begin payment on the day following completion of the elimination period as shown in the Schedule of Insurance. The weekly payments will continue as long as you remain disabled, up to the Maximum Benefit Period shown in the Schedule of Insurance.

If you are disabled for only part of a week, your weekly payment from us is pro-rated, and you will receive a payment equal to 1/7 of a full weekly payment for each day of the week you are disabled.

Successive periods of disability will be considered as one continuous period of disability if they:

1. resulted from, or are contributed to by, the same or related causes; and
2. are not separated by your return to full-time, active work for at least the number of days equal to two of your normal work weeks.

Disabilities due to accidental injuries under the Short Term Disability benefit means the covered accident must occur while you are insured under this benefit, and the disability must begin within 30 days of the date of the accident. If the disability begins after 30 days, it will be considered a sickness.

Weekly Benefit Calculations

Your Weekly Benefit If You Are Disabled and Not Working, or You Are Disabled and Working but Earning Less Than 20% of Your Weekly Earnings

Your weekly benefit will be determined by using the following steps:

Step 1: Multiply your weekly earnings by the benefit percentage shown in the Schedule of Insurance.

Step 2: Compare this amount to the maximum weekly benefit shown in the Schedule of Insurance.

Step 3: Take the lesser of the amounts from Steps 1 and 2. This is your weekly benefit.

Your Weekly Benefit If You Are Disabled and Working, Earning Between 20% and 80% of Your Weekly Earnings

Your weekly benefit will be determined by using the following steps:

Step 1: Multiply your weekly earnings by the benefit percentage shown in the Schedule of Insurance.

Step 2: Compare this amount to the maximum weekly benefit shown in the Schedule of Insurance.

Step 3: Take the lesser of the amounts from Steps 1 and 2. This is your gross weekly benefit.

Step 4: Add to the gross weekly benefit in step 3 the amount of any income you earn or receive from any form of employment. If this amount exceeds 100% of your weekly earnings, subtract the amount over 100% from your gross weekly benefit in Step 3. This is your weekly benefit.

If the total from Step 4 does not exceed 100% of your weekly earnings, your weekly benefit will not be reduced. Your weekly benefit will be as determined in Step 3.

Your loss of earnings must be as a result of or due to the same sickness or injury from which you are disabled.

If You Are Disabled and Working, Earning More Than 80% of Your Weekly Earnings, you are not eligible for a weekly benefit and no benefit will be paid.

Waiver of Premium Benefit

If a covered disability for which weekly benefits are payable has continued for 90 consecutive days, future payments will be waived as they fall due as long as benefits are payable. Premiums will not be waived beyond the Maximum Benefit Period. If coverage is to be continued, premium payments must be resumed following the period for which they were waived.

Termination of Benefit Payments

We will terminate benefit payments on the earliest of the following:

1. the date you are no longer disabled as defined; or
2. the date you fail to furnish Proof of Loss, when requested by us; or
3. the date you are no longer under the regular care of a physician, or refuse our request that you submit to an examination by a physician; or
4. the date you die; or
5. the date you are earning more than 80% of your pre-disability earnings; or
6. the date determined by the Maximum Benefit Period shown in the Schedule of Insurance.

Extension of Benefit Payments

If you are entitled to benefits while disabled and the policy terminates, benefits:

1. will continue as long as you remain disabled by the same disability; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination of the policy for any reason will have no effect on our liability under this provision.

Exclusions

We will not pay benefits for any disability caused by:

1. war or any act of war, or while serving in the armed forces of any country or international authority;
2. attempted suicide or intentional self-inflicted injury, while sane or insane;
3. your active participation in a riot or insurrection;
4. your voluntary commission of, or attempting to commit, an assault or felony; or participating in an illegal occupation;
5. injury arising out of or in the course of any occupation or employment for pay or profit, or any injury or sickness for which you are entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law;
6. your voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician;
7. injury occurring while intoxicated;
8. alcoholism or drug addiction;

9. elective or cosmetic surgery, except for surgery to repair damage to the natural body caused by an injury or treatment of a sickness; or
10. your acting as an organ donor.

No benefits are payable for any period of disability during which you are incarcerated in a penal or correctional facility for a period of 30 or more consecutive days.

Intoxicated means that you were under the influence of alcohol as determined by the laws of the jurisdiction in which the accident occurred. Conviction is not necessary for a determination of being intoxicated.

Participation in a riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot shall include all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together; whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

War means declared or undeclared war or a conflict involving the armed forces of any country, group of countries, governments, or international organization.