YOUR GROUP TERM LIFE INSURANCE PLAN

ODP International, LLC

D11513 (06/25)

GROUP TERM LIFE INSURANCE CERTIFICATE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 800-955-7736 www.voya.com

POLICYHOLDER:	ODP International, LLC
GROUP POLICY NUMBER:	74634-7GAT2
POLICY EFFECTIVE DATE:	January 1, 2025
POLICY ANNIVERSARY DATE:	January 1
GOVERNING JURISDICTION:	Florida

This Certificate provides life insurance for the Employees and spouse and children under riders, if any, of ODP International, LLC, 6600 North Military Trail, Boca Raton, Florida 33496 under the group Policy number listed above. The insured Employee will be given a copy of the group enrollment form. The benefits are payable to the Beneficiary of record designated by the insured Employee.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. Subject to the provisions of this Certificate, we certify that eligible Employees are insured for the benefits described in this Certificate.

This Certificate summarizes and explains the parts of the Policy which apply to you, if you are an eligible Employee as defined. The Certificate is part of the group Policy but by itself is not a policy. This Certificate replaces any other Certificates we may have given you under the Policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. Your rights and benefits under the Policy will not be less than those stated in your Certificate.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address.

In this Certificate, “you” and “your” refer to an Employee who is eligible for coverage under the Policy; “we”, “us” and “our” refer to ReliaStar Life Insurance Company.

READ THIS CERTIFICATE CAREFULLY! Insurance benefits may be subject to certain requirements, reductions, limitations and exclusions.

If you have a question about your coverage, if you need assistance with a problem, or if you have a claim, you may contact us at one of the phone numbers listed above.

GROUP TERM LIFE INSURANCE

Term life insurance provides a benefit to a named beneficiary upon the death of a person insured under a policy, with benefits payable only if a loss occurs within its term. Group insurance covers a group of persons under a single policy issued to a group policyholder.

Premiums for Basic life insurance are Noncontributory by insured Employees. Premiums for Supplemental life insurance are Contributory by insured Employees.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

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Policyholder's Contact Information:
ODP International, LLC, 6600 North Military Trail, Boca Raton, Florida 33496

California residents:
If you are age 65 or older on the effective date of any Contributory coverage under the Policy, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full Premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Maryland Residents:
The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

North Dakota Residents:
Please read this Certificate carefully. If you are not satisfied with it for any reason and no benefits have been paid, you may return it within 20 days after receipt for a refund of any Premium you paid.

West Virginia Residents:
Please read this Certificate carefully. If you are not satisfied with it for any reason, you may return it within 10 days after receipt for a refund of any Premium you paid.

SCHEDULE OF BENEFITS

EMPLOYER(S): ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

ELIGIBLE CLASS(ES)

All Eligible Associates that are Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT

Classified as a regular full-time associate scheduled to work at least 30 hours per week

ELIGIBILITY WAITING PERIOD

Persons in an eligible class on or before the Policy effective date: End of the month in which you complete a continuous period of 30 days of Active Employment

Persons entering an eligible class after the Policy effective date: End of the month in which you complete a continuous period of 30 days of Active Employment

WAIVER OF ELIGIBILITY WAITING PERIOD FOR ALL ELIGIBLE ASSOCIATES

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

CREDIT FOR PRIOR SERVICE FOR ALL ELIGIBLE ASSOCIATES

We will apply any prior period of work with the Employer toward the Eligibility Waiting Period to determine your eligibility date.

BASIC LIFE INSURANCE

Basic life insurance is Noncontributory by Employees.

Eligible Class(es)	Amount
Class 1: All Eligible Associates who are Classified as Vice President and Above	1 times your Basic Yearly Earnings
Class 2: All Other Eligible Associates	1 times your Basic Yearly Earnings

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF BASIC LIFE INSURANCE FOR CLASS 1 ASSOCIATES WHO ARE CLASSIFIED AS VICE PRESIDENT AND ABOVE

$500,000

MAXIMUM AMOUNT OF BASIC LIFE INSURANCE FOR CLASS 2 ALL OTHER ASSOCIATES

$250,000

SUPPLEMENTAL LIFE INSURANCE

Supplemental life insurance is Contributory by Employees.

Eligible Class(es)	Amount
Class 1: All Eligible Associates who are Classified as Vice President and Above	Choice of 1, 2, 3, 4, 5, 6 or 7 times your Basic Yearly Earnings, with a minimum of $10,000
Class 2: All Other Eligible Associates	Choice of 1, 2, 3, 4, 5, 6 or 7 times your Basic Yearly Earnings, with a minimum of $10,000

An insurance amount that does not equal an increment of $10,000 is rounded to the next higher $10,000.

MAXIMUM AMOUNT OF BASIC PLUS SUPPLEMENTAL LIFE INSURANCE FOR CLASS 1 ASSOCIATES

$3,000,000

MAXIMUM AMOUNT OF BASIC PLUS SUPPLEMENTAL LIFE INSURANCE FOR CLASS 2 ASSOCIATES

$2,250,000

BENEFIT REDUCTIONS FOR ALL ELIGIBLE ASSOCIATES

Your insurance amount will decrease as follows:

- To 65% of the original amount on the Policy anniversary that is on or next follows your 65th birthday.
- To 45% of the original amount on the Policy anniversary that is on or next follows your 70th birthday.
- To 30% of the original amount on the Policy anniversary that is on or next follows your 75th birthday.
- To 20% of the original amount on the Policy anniversary that is on or next follows your 80th birthday.
- To 15% of the original amount on the Policy anniversary that is on or next follows your 85th birthday.

Reduced insurance amounts are not rounded.

DEFINITIONS

Active Employment or **Active Employee** means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Basic Yearly Earnings means the yearly salary or wage you receive for work done for the Employer as of the later of the Policy effective date, or the immediately preceding Policy anniversary date, or your hire date. It does not include bonuses, commissions or overtime pay.

Beneficiary means the person(s) or entity to whom we will pay the life insurance benefits in accordance with the BENEFICIARY and PAYMENT OF PROCEEDS provisions.

Certificate means this document that describes the benefits and rights of insured Employees under the Policy. It may include riders, endorsements or amendments.

Contributory means insurance for which insured Employees are required to pay any part of the Premium.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States, including its territories and possessions, and who is in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Evidence of Insurability means your affirmation, on a form acceptable to us, of various factors that we will use to determine if you are approved for coverage. Those factors may include, your medical history and treatment, driving record, and/or family medical history. We may also, at our expense, request additional information to determine your eligibility for coverage.

Noncontributory means insurance for which insured Employees are not required to pay any part of the Premium.

Policy means the Written group insurance contract between us and the Policyholder, including the Certificates issued to insured Employees. It may include riders, endorsements or amendments.

Policyholder means the entity to whom the Policy is issued, as shown on the first page of this Certificate.

Premium(s) means the amount the Policyholder and/or you must pay to us for the insurance provided under the Policy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

Written or **Writing** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

If you are an Employee in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period, unless waived.

ENROLLMENT

If you are eligible for Contributory coverage, you must enroll for any Contributory coverage before it will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment. You may need to provide Evidence of Insurability, as described below.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and you were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective.

Basic Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or the plan maximum
Initial eligibility under the Employer's plan for basic coverage on or after the Policy effective date…	Evidence is not required for any amount less than or equal to the plan maximum
Increases due to salary, job or class changes…	Evidence is not required for any increase in which the total Basic Life Insurance amount is less than or equal to the plan maximum

Supplemental Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or the plan maximum
Initial eligibility under the Employer's plan for supplemental coverage on or after the Policy effective date…	Any amount exceeding $500,000 or 3 times your basic yearly earnings, whichever is less.
Enrollment for supplemental coverage on the Policy effective date, for employees who had supplemental coverage under the Employer's prior Policy…	Any increased amount exceeding 1 times your basic yearly earnings. Any total Supplemental Life insurance exceeding $500,000 or 3 times your basic yearly earnings, whichever is less.
Enrollment for supplemental coverage on the Policy effective date, for employees who had no supplemental coverage under the Employer's prior Policy…	Any increased amount exceeding 1 times your basic yearly earnings. Any total Supplemental Life insurance exceeding $500,000 or 3 times your basic yearly earnings, whichever is less.
Enrollment at a scheduled annual enrollment period after the Policy effective date for an increase to existing supplemental coverage…	Any increased amount exceeding 1 times your basic yearly earnings. Any total Supplemental Life insurance exceeding $500,000 or 3 times your basic yearly earnings, whichever is less.

Enrollment at a scheduled annual enrollment period after the Policy effective date for initial supplemental coverage…	Any increased amount exceeding 1 times your basic yearly earnings. Any total Supplemental Life insurance exceeding $500,000 or 3 times your basic yearly earnings, whichever is less.
Enrollment within 31 days after a change in family status as documented and approved by the Employer and valid during this enrollment…	Any increased amount exceeding 1 times your basic yearly earnings. Any total Supplemental Life insurance exceeding $500,000 or 3 times your basic yearly earnings, whichever is less.
Any new or increased supplemental coverage not described above, including enrollments more than 31 days after initial eligibility…	All increased amounts

EFFECTIVE DATE OF COVERAGE

For Noncontributory coverage, you will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for coverage.

For Contributory coverage, you will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you enroll for coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for coverage.
- The first day of the month that is on or next follows the date we approve your Evidence of Insurability, if Evidence of Insurability is required.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The first day of the month that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The first day of the month that is on or next follows the date we approve your Evidence of Insurability, if Evidence of Insurability is required.

Any decrease in coverage other than benefit reductions noted on the SCHEDULE OF BENEFITS will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

We will provide continuity of coverage under our Policy if both of the following are true:

- You are not in Active Employment due to sickness or injury or due to an Employer-approved non-medical leave of absence on the date the Employer changes insurance carriers to our Policy.
- You were covered under the prior group life policy, including payment of premiums to the prior insurance carrier when due, on the day before the coverage for your eligible class under our Policy became effective.

You are not eligible under this provision if any of the following are true:

- Your coverage is being continued under a waiver of premium (or any similar) provision of the prior policy.
- Your coverage is being continued under a continuation or portability provision of the prior policy.
- You converted your coverage with the prior insurance carrier.
- You are not in Active Employment due to reasons other than sickness, injury or an Employer-approved non-medical leave of absence.

If you are eligible for continuity of coverage under this provision, we will provide limited coverage under our Policy. Coverage under this provision will begin on the date your eligible class is covered under our Policy and will continue until the earliest of the following:

- The date you return to Active Employment.
- The date the Employer-approved leave of absence ends.
- The date your continuation would end under the terms of our Policy.
- The date your continuation would have ended under the terms of the prior policy.
- The date coverage would otherwise end, according to the provisions of our Policy.
- 12 months following the date you were last in Active Employment.

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

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior policy had it remained in force, or the amount you are eligible for under our Policy. We will reduce our payment by any amount paid under the prior policy.

If your coverage under this provision ends while the Policy is in force, and you are not otherwise eligible for insurance under the Policy, then you will be eligible for conversion as described in the CONVERSION provision.

If you were not covered under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE OF COVERAGE provision will apply.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date coverage for all Active Employees under the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your Contributory coverage, as allowed by the Employer.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Policy grace period.
- The last day you are in Active Employment.

We will pay benefits for a loss that occurs while you are covered under the Policy.

CONVERSION

You may convert your life insurance, without Evidence of Insurability, to an individual life insurance policy if any part of your life insurance under the Policy stops for one of the following reasons:

- Your coverage ends according to the TERMINATION OF COVERAGE provision other than your voluntary cancellation of your Contributory coverage.
- Any continuation of insurance under the Policy ends.
- Your coverage reduces due to BENEFIT REDUCTIONS as described on the SCHEDULE OF BENEFITS.
- Your coverage reduces due to your change from one eligible class to another.
- Your coverage reduces due to a Policy change.

Only life insurance is eligible for conversion. The maximum amount of life insurance you are eligible to convert cannot be greater than the amount of life insurance you had prior to termination. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which you remain eligible under the Policy are not eligible for conversion.

To convert your life insurance, you must apply and pay the first premium to us within 31 days of the date any part of your life insurance under the Policy terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of your life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

You may apply to convert the entire amount of life insurance that is terminating under the Policy, or a lesser amount. The maximum amount of life insurance coverage you are eligible to convert will be reduced by any amount of life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your class of risk, and your attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept your application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, your life insurance will continue under the terms of the Policy. If you die within the conversion period, any life insurance amount that you were entitled to convert will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

If you have made an absolute assignment of your insurance, only the current owner may apply for conversion.

INCONTESTABILITY

Any statement made by you is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you and a copy of such statement of insurability has been given to you or to the Beneficiary. We will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your lifetime. We will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your lifetime.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the Premium.

An error will not end insurance validly in effect, nor will it continue insurance validly ended.

MISSTATEMENT OF AGE

If Premiums are based on your age and you have misstated your age, then your correct age will be used to determine if insurance is in effect and, as appropriate, the Premium and/or benefits will be adjusted. We may require satisfactory proof of your age before paying any claim.

ASSIGNMENT

You may make an absolute assignment of ownership of your insurance under the Policy to any person or entity by sending us Written notice on a form that we accept. An absolute assignment transfers all your duties, rights, title and interest under the Policy to the new owner. The new owner can make any changes allowed under the Policy and Certificate.

An absolute assignment form is available from the Employer or us. Any assignment form must be Signed by both the current owner and the new owner. The Signed form must be received and accepted by us in order to be valid. An accepted assignment will take effect on the date the form is Signed by you, unless otherwise specified in the Signed form. An assignment does not affect any payment we make or action we take before receiving the Signed form. An assignment does not change the insurance or the Beneficiary designation.

If you want to continue an absolute assignment made under the Employer's prior group life insurance policy, a statement of intent form is available from the Employer or us. The form must be Signed by both you and the assignee. The Signed form must be received and accepted by us in order to be valid. A statement of intent does not affect any payment we make or action we take before receiving the Signed form. A statement of intent does not change the insurance or the Beneficiary designation.

We assume no responsibility for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

BENEFICIARY

The Beneficiary is named by you to receive any proceeds payable at your death. While your coverage is in force, you may change the Beneficiary designation by Written request on a form that is acceptable to us. A Beneficiary designation form is available from the Employer or us. An accepted designation will take effect as of the date it is Signed, unless you specify otherwise in the Signed designation, but will not affect any payment we make or action we take before receiving the Signed form. If you have made an absolute assignment of your insurance, only the current owner may change the Beneficiary designation.

If an irrevocable Beneficiary is named, the Beneficiary designation can only be changed with the consent of the irrevocable Beneficiary.

There can be one or more Beneficiaries. If two or more Beneficiaries are named and their shares are not specified in the Beneficiary designation, then the Beneficiaries will share any insurance proceeds equally. If a primary Beneficiary does not survive you, their share will be payable to the remaining primary Beneficiaries. One or more contingent Beneficiaries may be named to receive the proceeds in the event that all of the primary Beneficiaries named do not survive you.

Please refer to the LIFE INSURANCE BENEFITS section of the Certificate for information about payment.

AGENCY

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

ENTIRE CONTRACT

Coverage for insured Employees is provided under a contract of group term insurance between us and the Policyholder. The entire contract consists of all of the following:

- The Policy issued to the Policyholder including Part A and Part B.
- The Certificates which are made part of Part B under the Policy.
- Any riders, endorsements and/or amendments issued.
- The Policyholder's Signed application, a copy of which is attached to the Policy when issued.

CHANGES TO POLICY OR CERTIFICATE

The terms and provisions of the Policy and this Certificate may be changed at any time by Written agreement between us and the Policyholder. We will issue riders, endorsements or amendments to effect such changes, and only those forms Signed by one of our executive officers will be valid. We will only make changes consistent with the standards of the applicable regulatory body in the governing jurisdiction. We will provide a copy of the rider, endorsement or amendment to the Policyholder for attachment to the Policy, and also for the Employees if the change affects the Certificate(s).

Riders, endorsements and amendments are subject to prior approval by the appropriate regulatory body in the governing jurisdiction. A rider, endorsement or amendment will not affect the insurance provided under the Certificate(s) until the effective date of the change, unless retroactivity is required by the applicable regulatory body.

No agent, representative or employee of ours or of any other entity, except one of our executive officers, may approve a change to or waive the terms of the Policy.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that you died while your insurance under the Policy is in force. The death benefit is the amount of life insurance for your class as shown on the SCHEDULE OF BENEFITS in effect on the date of your death minus any amount paid under the Accelerated Death Benefit Rider.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review the claim and proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this Certificate.

AUTOPSY

We reserve the right to make a reasonable request for an autopsy at our expense where permitted by law.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your death.

If there is no eligible Beneficiary, we will pay the proceeds to the first survivor(s), who is living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your estate.

If the Beneficiary or survivor is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to that person's estate.

"Spouse" means your lawful spouse. It includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include: the

establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

LEGAL ACTION

Legal action regarding any claim under the Policy may not be taken after 5 years from the time proof of loss must be submitted. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide Written notice of the adverse benefit determination to the claimant as soon as possible, but no more than 90 days after receipt of the claim unless an extension is needed. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension before the end of the initial 90-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to the claimant's failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

A notice of an adverse benefit determination will be Written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
- A description of the claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

The claimant may request a review of an adverse benefit determination (an "appeal") at any time during the 60 day period following receipt of the notice of the determination. We will consider an appeal upon Written application of the claimant or his or her duly authorized representative. As part of the appeal the claimant also has the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits. The claimant may, in the course of this appeal, review relevant documents and submit to us Written comments, documents, records and other information relevant to the claimant's claim for benefits.

Following our review of the appeal, we will provide the claimant with a Written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 60 days after the receipt of the appeal unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice of any such extension before the end of the 60-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to the claimant's failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be Written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- 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.
- A statement of the claimant's right to bring a civil action.

EXCLUSIONS AND LIMITATIONS

For Noncontributory life insurance, we pay a death benefit for all causes of death.

For Supplemental Contributory life insurance, if you commit suicide while sane or insane within two years of the date your insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period you were continuously covered under the Policy and any previous group term life policy(ies) issued to the Policyholder during your lifetime.

If you commit suicide while sane or insane within two years from the date an increase in Supplemental Contributory life insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

SPOUSE LIFE INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

SUPPLEMENTAL SPOUSE LIFE INSURANCE
Supplemental Spouse life insurance is Contributory by Employees.

Eligible Class(es)	Amount
Spouse	Choice of $10,000 to $250,000 in $10,000 increments

MAXIMUM AMOUNT OF SUPPLEMENTAL SPOUSE LIFE INSURANCE
$250,000

The Supplemental Spouse life insurance amount will not exceed the Basic plus Supplemental Employee life insurance amount in force.

DEFINITIONS

Evidence of Insurability means your Spouse's affirmation, on a form acceptable to us, of various factors that we will use to determine if your Spouse's coverage is approved. Those factors may include, but are not limited to, your Spouse's medical history and treatment, driving record, and/or family medical history. If we need more information, any costs will be at our expense.

Spouse means your lawful spouse. The person must also meet all of the following:
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee.

The term includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

ENROLLMENT

If you have a Spouse eligible for coverage, you must enroll for Contributory Spouse coverage before Contributory coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and your Spouse was covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage on your Spouse that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

You may need to provide Evidence of Insurability on your Spouse, as described below.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective.

Supplemental Spouse Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or the plan maximum
Initial eligibility under the Employer's plan for supplemental spouse coverage on or after the Policy effective date…	Evidence is not required for any amount less than or equal to $50,000
Enrollment for supplemental spouse coverage on the Policy effective date, for employees who had supplemental spouse coverage under the Employer's prior Policy…	Any increased amount exceeding 1 plan increment. Any total Supplemental Spouse Life Insurance exceeding $50,000
Enrollment for supplemental spouse coverage on the Policy effective date, for employees who had no supplemental spouse coverage under the Employer's prior Policy…	Any increased amount exceeding 1 plan increment. Any total Supplemental Spouse Life Insurance exceeding $50,000
Enrollment at a scheduled annual enrollment period after the Policy effective date for an increase to existing supplemental spouse coverage…	Any increased amount exceeding 1 plan increment. Any total Supplemental Spouse Life Insurance exceeding $50,000

Enrollment at a scheduled annual enrollment period after the Policy effective date for initial supplemental spouse coverage…	Any increased amount exceeding 1 plan increment. Any total Supplemental Spouse Life Insurance exceeding $50,000
Enrollment within 31 days after a change in family status as documented and approved by the Employer and valid during this enrollment…	Any increased amount exceeding 1 plan increment. Any total Supplemental Spouse Life Insurance exceeding $50,000
Any new or increased supplemental spouse coverage not described above, including enrollments more than 31 days after initial eligibility…	All increased amounts

EFFECTIVE DATE OF COVERAGE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for Spouse coverage.
- The first day of the month that is on or next follows the date we approve your Spouse's Evidence of Insurability, if Evidence of Insurability is required.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- The first day of the month that is on or next follows the date your Spouse is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date your Spouse's coverage would otherwise become effective.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The first day of the month that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The first day of the month that is on or next follows the date we approve your Spouse's Evidence of Insurability, if Evidence of Insurability is required.
- The first day of the month that is on or next follows the date your Spouse is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date the increased or additional coverage would otherwise start.

Any decrease in coverage will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If your coverage is being provided under the CHANGE OF INSURANCE CARRIERS provision in the Certificate, then we will also provide continuity of Spouse coverage under the same conditions and for the same duration.

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior policy had it remained in force, or the amount of eligible Spouse coverage under our Policy. We will reduce our payment by any amount paid under the prior policy.

If Spouse coverage under this provision ends while the Policy is in force, and your Spouse is not otherwise eligible for insurance under the Policy, then your Spouse coverage will be eligible for conversion as described in the CONVERSION provision.

If your Spouse was not covered under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE OF COVERAGE provision will apply.

SPOUSE ACTIVE MILITARY DUTY

If your Spouse is insured under this rider and your Spouse begins full-time active duty in the armed forces of any country or subdivision thereof, then you should notify the Policyholder to cancel this rider. Coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse's full time active military duty ends, then Spouse coverage under this rider will become effective on the date your Spouse is again eligible for coverage.

If your Spouse's full-time active military duty ends, then you may re-enroll for Contributory Spouse coverage under this rider subject to the following:

- If you re-enroll for Contributory Spouse coverage within 2 months of the date your Spouse is again eligible for coverage, then the maximum amount of Contributory Spouse coverage available will be the lesser of the amount that was in effect on the day before coverage ended and the then current maximum amount of Contributory Spouse coverage available under this rider. Contributory Spouse coverage will become effective on the later of the following:
  - The date you re-enroll for Contributory Spouse coverage, if you are in Active Employment.
  - The date your Spouse is not hospitalized or confined at home under a doctor's care.
  - The date your Spouse is not receiving or applying to receive disability benefits from any source.
  - The date you return to Active Employment, if you are not in Active Employment when your Contributory Spouse coverage would otherwise become effective. **Exception:** Contributory coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- If you re-enroll for Contributory Spouse coverage more than 2 months after your Spouse is again eligible for coverage, then Evidence of Insurability on your Spouse will be required. If Evidence of Insurability is approved by us, Contributory Spouse coverage will become effective on the date specified by us.

SPOUSE CHANGE OF LEGAL RESIDENCE

If your Spouse is insured under this rider and your Spouse changes their legal residence to outside the United States or its territories or possessions, then you should notify the Policyholder to cancel this rider. Coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse resumes legal residence in the United State or its territories or possessions, then Spouse coverage under this rider will become effective on the date your Spouse is again eligible for coverage.

If your Spouse resumes legal residence in the United States or its territories or possessions, then you may re-enroll for Contributory Spouse coverage this rider subject to the following:

- If you re-enroll for Contributory Spouse coverage within 2 months of the date your Spouse is again eligible for coverage, then the maximum amount of Contributory Spouse coverage available will be the lesser of the amount that was in effect on the day before coverage ended and the then current maximum amount of Contributory Spouse coverage available under this rider. Contributory Spouse coverage will become effective on the later of the following:
  - The date you re-enroll for Contributory Spouse coverage, if you are in Active Employment.
  - The date your Spouse is not hospitalized or confined at home under a doctor's care.
  - The date your Spouse is not receiving or applying to receive disability benefits from any source.
  - The date you return to Active Employment, if you are not in Active Employment when your Contributory Spouse coverage would otherwise become effective. **Exception:** Contributory coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

- If you re-enroll for Contributory Spouse coverage more than 2 months after your Spouse is again eligible for coverage, then Evidence of Insurability on your Spouse will be required. If Evidence of Insurability is approved by us, Contributory Spouse coverage will become effective on the date specified by us.

TERMINATION OF COVERAGE

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you voluntarily cancel this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The date your Spouse is no longer an eligible Spouse as defined by this rider.
- The end of the period for which Premiums for this rider are paid if the next Premium is not paid by its due date, subject to the Policy grace period.

We will pay benefits for a loss that occurs while your Spouse is insured under this rider.

CONVERSION

You may convert Spouse life insurance, without Evidence of Insurability, to an individual life insurance policy if Spouse life insurance under this rider stops for any reason other than nonpayment of Premium, your voluntary cancellation of this rider, your Spouse ceasing to be an eligible Spouse as defined, or your death. You may also convert any part of Spouse life insurance that reduces due to your change from one eligible class to another or a Policy change. If you have made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Spouse may convert Spouse life insurance, without Evidence of Insurability, to an individual life insurance policy if Spouse life insurance under this rider stops because your Spouse is no longer an eligible Spouse as defined, or because of your death.

Only life insurance is eligible for conversion. The maximum amount of life insurance eligible for conversion cannot be greater than the amount of Spouse life insurance you had prior to termination. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which your Spouse remains eligible under the Policy are not eligible for conversion.

To convert Spouse life insurance, application must be made and the first premium paid to us within 31 days of the date any part of Spouse life insurance under this rider terminates (the “conversion period”). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of Spouse life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

Application for conversion may be for the entire amount of Spouse life insurance that is terminating under this rider, or a lesser amount. The maximum amount of Spouse life insurance coverage eligible for conversion will be reduced by any amount of Spouse life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your Spouse’s class of risk, and your Spouse’s attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, Spouse life insurance will continue under the terms of this rider. If your Spouse dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

INCONTESTABILITY

Any statement made by you or your Spouse is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you or your Spouse and a copy of such statement of insurability has been given to you or to the Beneficiary. We will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your Spouse's lifetime. We will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your Spouse's lifetime.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

MISSTATEMENT OF AGE

If Premiums are based on your Spouse's age and you have misstated your Spouse's age, then your Spouse's correct age will be used to determine if insurance is in effect and, as appropriate, the Premium and/or benefits will be adjusted. We may require satisfactory proof of your Spouse's age before paying any claim.

BENEFICIARY

You are the Beneficiary for proceeds that become payable at your Spouse's death under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. You, or the current owner if ownership was assigned, are automatically the Beneficiary for these proceeds and this designation may not be changed. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death or divorce. If the Beneficiary is not living on the date payment if made, benefits are payable to the Beneficiary's estate. Please refer to the LIFE INSURANCE BENEFITS section for more information about payment.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that your Spouse died while Spouse insurance under this rider is in force. See the CONVERSION provision for information about death benefits payable during the conversion period following your death. The death benefit is the amount of Spouse life insurance for the eligible class as shown on the SCHEDULE OF BENEFITS in effect on the date of your Spouse's death minus any amount paid under the Accelerated Death Benefit Rider.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your Spouse's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this rider.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Spouse's death. **Exception:** If your Spouse dies during the conversion period following your death and you would otherwise have been the Beneficiary, we will pay the proceeds to your estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your Spouse's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

EXCLUSIONS AND LIMITATIONS

If your Spouse commits suicide while sane or insane within two years of the date Spouse insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period your Spouse was continuously covered under this rider and any previous group term life policy issued to the Policyholder during your Spouse's lifetime.

If your Spouse commits suicide while sane or insane within two years from the date an increase in Supplemental Spouse life insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

CHILDREN'S LIFE INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

SUPPLEMENTAL CHILDREN'S LIFE INSURANCE
Supplemental Children's life insurance is Contributory by Employees.

Eligible Class(es)	Amount
Child	Choice of $5,000 to $25,000 in $5,000 increments

The amount for a stillborn Child is 25% of the lowest amount shown above.

MAXIMUM AMOUNT OF SUPPLEMENTAL CHILDREN'S LIFE INSURANCE
$25,000

The Supplemental Children's life insurance amount will not exceed the Supplemental Employee life insurance amount in force.

You may not elect a higher amount of Supplemental Children's life insurance than Supplemental Employee life insurance.

DEFINITIONS

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child for whom you are a legal guardian.

The child must also meet all of the following conditions:

- Be unmarried.
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.
- Not be insured by an individual policy that was issued under any conversion right of this rider.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit. If the Child becomes capable of self-sustaining employment and proof of the Child's incapacity can no longer be furnished to us, you may convert your Child's life insurance to an individual life insurance policy as described in the CONVERSION provision of this rider.

Evidence of Insurability means your affirmation, on a form acceptable to us, of various factors that we will use to determine if your Child's coverage is approved. Those factors may include, your Child's medical history and treatment, driving record, and/or family medical history. If we need more information, any costs will be at our expense.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

ENROLLMENT

If you have a Child eligible for coverage, you must enroll for Contributory Children's coverage before Contributory coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and your Children were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage on your Children that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

You may need to provide Evidence of Insurability on your Children, as described below.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective. When you have Children covered under this rider, then newly eligible Children will not require Evidence of Insurability.

Supplemental Child Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or the plan maximum
Initial eligibility under the Employer's plan for supplemental children's coverage on or after the Policy effective date…	Evidence is not required for any amount less than or equal to the plan maximum
Enrollment for supplemental children's coverage on the Policy effective date, for employees who had supplemental children's coverage under the Employer's prior Policy…	Evidence is not required for any amount less than or equal to the plan maximum
Enrollment for supplemental children's coverage on the Policy effective date, for employees who had no supplemental children's coverage under the Employer's prior Policy…	Evidence is not required for any amount less than or equal to the plan maximum
Any new or increased supplemental child coverage not described above, including enrollments more than 31 days after initial eligibility…	All increased amounts

EFFECTIVE DATE OF COVERAGE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you enroll for Children's coverage on or before that date.
- The first day of the month that is on or next follows the date we approve each Child's Evidence of Insurability, if Evidence of Insurability is required.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- The first day of the month that is on or next follows the date your Child is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date that Child's coverage would otherwise become effective. **Exception**: This does not apply to a newborn.

Your eligible newborn Child is automatically covered for the first 31 days after birth. This includes an adopted newborn Child who is placed with you within 31 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then Contributory coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 31st day is subject to the conditions regarding application and Active Employment.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 31 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 31 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The first day of the month that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The first day of the month that is on or next follows the date we approve each Child's Evidence of Insurability, if Evidence of Insurability is required.
- The first day of the month that is on or next follows the date your Child is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date that Child's increased or additional coverage would otherwise start.

Any decrease in coverage will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If your coverage is being provided under the CHANGE OF INSURANCE CARRIERS provision in the Certificate, then we will also provide continuity of Children's coverage under the same conditions and for the same duration.

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior policy had it remained in force, or the amount of eligible Children's coverage under our Policy. We will reduce our payment by any amount paid under the prior policy.

If Children's coverage under this provision ends while the Policy is in force, and your Children are not otherwise eligible for insurance under the Policy, then your Children's coverage will be eligible for conversion as described in the CONVERSION provision.

If your Children were not covered under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE OF COVERAGE provision will apply.

TERMINATION OF COVERAGE

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you voluntarily cancel this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The date you no longer have an eligible Child as defined by this rider.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Policy's grace period.

If coverage for your Children ends and this rider terminates because you no longer have an eligible Child as defined by this rider, then you should notify the Policyholder to cancel this rider.

We will pay benefits for a loss that occurs while your Child is insured under this rider.

CONVERSION

You may convert Children's life insurance, without Evidence of Insurability, to an individual life insurance policy if a Child's life insurance under this rider stops for any reason other than nonpayment of Premium, your voluntary cancellation of this rider, your Child reaching the termination age under this rider, or your death. You may also convert any part of Children's life insurance that reduces due to your change from one eligible class to another or a Policy change. If you have made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Child may convert Children's life insurance, without Evidence of Insurability, to an individual life insurance policy if that Child's life insurance under this rider stops because your Child reaches the termination age under this rider, or because of your death. If a Child is too young to contract for life insurance after your death, then a parent or a court-appointed guardian of the Child may apply for conversion of that Child's coverage.

Only life insurance is eligible for conversion. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which your Child remains eligible under the Policy are not eligible for conversion.

To convert Children's life insurance, application must be made and the first premium paid to us within 31 days of the date any part of a Child's life insurance under this rider terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of Children's life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

Application for conversion may be for the entire amount of Children's life insurance that is terminating under this rider, or a lesser amount. The maximum amount of Children's life insurance coverage eligible for conversion will be reduced by any amount of Children's life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your Child's class of risk, and your Child's attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, Children's life insurance will continue under the terms of this rider. If your Child dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

INCONTESTABILITY

Any statement made by you or your Child is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you or your Child and a copy of such statement of insurability has been given to you or to the Beneficiary. We will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your Child's lifetime. We will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your Child's lifetime.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

BENEFICIARY

You are the Beneficiary for proceeds that become payable at your Child's death under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. You, or the current owner if ownership was assigned, are automatically the Beneficiary for these proceeds and this designation may not be changed. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death. Please refer to the LIFE INSURANCE BENEFITS section for more information about payment.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that your Child died while Children's insurance under this rider is in force. See the CONVERSION provision for information about death benefits payable during the conversion period following your death. The death benefit is the amount of Children's life insurance on that Child for the eligible class as shown on the SCHEDULE OF BENEFITS in effect on the date of your Child's death.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your Child's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this rider.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Child's death. **Exception:** If your Child dies during the conversion period following your death and you would otherwise have been the Beneficiary, we will pay the proceeds to your estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your Child's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

EXCLUSIONS AND LIMITATIONS

If your Child commits suicide while sane or insane within two years of the date that Child's insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period your Child was continuously covered under this rider and any previous group term life policy issued to the Policyholder during your Child's lifetime.

If your Child commits suicide while sane or insane within two years from the date an increase in Supplemental Children's life insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

Executed at our Home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

WAIVER OF PREMIUM RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform for remuneration or profit any other job for which you are fit by education, training or experience. If we pay you an Employee benefit under the Accelerated Death Benefit Rider, you will automatically meet the definition of Total Disability under this rider.

Waiting Period means the 6 month period immediately following the date you stop Active Employment during which you are continuously Totally Disabled. If you return to work for a total of 30 days or less during the Waiting Period and then stop work again due to the same Total Disability, your Waiting Period will not be interrupted. If we pay you an Employee benefit under the Accelerated Death Benefit Rider, you will automatically satisfy the Waiting Period requirement under this rider.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date life insurance coverage is being continued under the terms of the Portability Rider.

This rider will not terminate while Premiums are being waived under the terms of this rider.

TERMINATION OF COVERAGE

The TERMINATION OF COVERAGE provision in your Certificate is revised to add this item to the terms under which your coverage ends:

- The date Premiums are no longer being waived under the Waiver of Premium Rider, if you are not in an eligible class on that date.

The TERMINATION OF COVERAGE provision in your Spouse Life Insurance Rider is revised to add this item to the terms under which your Spouse coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

The TERMINATION OF COVERAGE provision in your Children's Life Insurance Rider is revised to add this item to the terms under which your Children's coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

WAIVER OF PREMIUM BENEFIT

If you become Totally Disabled while covered under this rider and meet the other conditions below, we will waive Premiums due under the Policy and continue insurance during your Total Disability, according to the terms of this rider. When we waive Premiums, the amount of continued life insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums that are waived are not deducted from any proceeds that may become payable.

Continued life insurance includes the following if effective on the date before your Total Disability began:

- Employee life insurance.
- the Accelerated Death Benefit Rider.

Continued life insurance does not include:

- the Spouse Life Insurance Rider.
- the Children's Life Insurance Rider.
- the AD&D Rider.
- the Portability Rider.
- any continuation rider(s).

Any rider or coverage that is not eligible for waiver of premium under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment. See the CONVERSION provision of the Certificate and riders for more information about conversion.

Continued insurance is subject to all other terms of the Policy.

CONDITIONS FOR WAIVER OF PREMIUM

All of the following conditions must be met in order to waive Premiums:

- Total Disability begins before your 60th birthday.
- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire Waiting Period and up to the date we approve your claim for waiver of Premium. Premiums due for life insurance and this rider are subject to the provisions of any continuation riders.
- You provide notice of claim and proof of Total Disability to us as described below.

NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY

You must send us written notice of claim while you are living, while you are Totally Disabled, and within 9 months of the date your Total Disability begins. Failure to give notice within 9 months will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of your Total Disability. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). Claim forms are available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

If you die within 12 months of the date your Total Disability began and all of the following are true:

- You didn't previously submit a claim under this rider, and
- You would otherwise have met the CONDITIONS FOR WAIVER OF PREMIUM, and
- Life insurance for you would still have been in force under the Policy on the date of your death if a claim for waiver of Premium had been approved, then the Beneficiary can submit a claim for death benefit proceeds along with notice of claim under this rider and proof that your Total Disability continued without interruption from the last day you were in Active Employment until your death.

EFFECTIVE DATE OF WAIVER OF PREMIUM

When we approve your claim, Premiums are waived as of the date after the Waiting Period ends. We will refund any Premiums we received after that date to the Policyholder or to you, as appropriate. We will notify you in writing when your claim is approved.

We will notify you and the Employer if we deny your claim. If we deny your claim, conversion is available as described in the CONVERSION provision of the Certificate and riders.

If we approve a claim for which notice of claim was provided to us more than 12 months after the date your Total Disability began, then any refund of Premiums will not exceed 12 months of Premiums dating back from the date the notice of claim was received by us.

If you converted life insurance due to your termination of Active Employment and then a claim under this rider is approved, the conversion policy must be surrendered without claim. We will cancel the conversion policy as of the date of issue and refund any premiums paid. We will retain any beneficiary designation you made under your conversion policy as the Beneficiary under the group Policy, unless you change the Beneficiary as described under the BENEFICIARY provision in the Certificate. If the conversion policy is not surrendered without claim, then Premiums will not be waived under this rider. The same coverage(s) that would otherwise end due to your termination of Active Employment may not be both continued under this rider and converted.

PROOF OF CONTINUED TOTAL DISABILITY

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

TERMINATION OF WAIVER OF PREMIUM

We will stop waiving Premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.

If Premiums are no longer waived, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your Premium payments are resumed.

You will not be eligible for portability under any Portability Rider on the date we stop waiving your Premiums.

CONVERSION AFTER TERMINATION OF WAIVER OF PREMIUM

When Waiver of Premium under this rider ends, and if you are not otherwise eligible for insurance under the Policy, then conversion will be available as described in the CONVERSION provision of the Certificate and riders.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an “adverse benefit determination”), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an “appeal”) at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit

determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Prior to rendering an adverse decision on appeal, we will provide notice to you of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. We will also notify you if we have new or additional rationale for an adverse appeal determination. We will then provide you with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for your response.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

ACCELERATED DEATH BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

THE AMOUNT OF LIFE INSURANCE WILL BE REDUCED IF AN ACCELERATED DEATH BENEFIT IS PAID. PREMIUM PAYMENTS WILL ALSO BE REDUCED. THE RECEIPT OF ACCELERATED DEATH BENEFITS MAY BE A TAXABLE EVENT. YOU SHOULD SEEK ADDITIONAL INFORMATION ABOUT THE TAX STATUS OF THE PAYMENT FROM A PERSONAL TAX ADVISOR.

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SCHEDULE OF BENEFITS

Accelerated Death Benefit

You:	90% of the amount of Basic and Supplemental Life Insurance in force, or $1,500,000, whichever is less.
Your Spouse:	90% of the amount of Supplemental Spouse Life Insurance in force.

The Covered Person must have at least $10,000 of life insurance coverage in force.

Your Spouse must have at least $10,000 of life insurance coverage in force.

DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Institution means any hospital, convalescent hospital, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons.

Qualifying Event means either of the following:
- Terminal Illness.
- A medical condition that is reasonably expected to require continuous confinement in an Institution and the Covered Person is expected to remain there for the rest of his or her life.

Terminal Illness means a medical condition that is expected to result in the Covered Person's death within 12 months and from which there is no reasonable chance of recovery.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER
This rider terminates on the earliest of the following:
- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

This rider will not terminate while this rider is being continued under the terms of another rider.

Termination of this rider will not prejudice the payment of benefits for a Qualifying Event that occurred while this rider was in force.

CONVERSION
When this rider terminates, conversion of this rider is not available.

ACCELERATED DEATH BENEFIT

Accelerated death benefit proceeds is the amount we pay to you, while a Covered Person is living, if the Covered Person has a Qualifying Event. The accelerated death benefit proceeds are paid only once per Covered Person. This payout is the only settlement option available prior to a Covered Person's death.

The benefit is the amount of the accelerated death benefit shown on the SCHEDULE OF BENEFITS in effect on the date you request accelerated death benefit proceeds.

CONDITIONS FOR THE ACCELERATED DEATH BENEFIT
To receive a benefit payment under this rider, all of the following conditions must be met:
- Any required life insurance Premium is paid through the date you request proceeds under this rider.
- You request proceeds in writing while the Covered Person is living and before the Covered Person attains age 65. If you are unable to request payment yourself, your legal representative may request it on your behalf.
- The Covered Person is insured for life insurance benefits under the Policy.
- The Covered Person is insured for the minimum amount of life insurance as shown on the SCHEDULE OF BENEFITS in order to be eligible for benefits under this rider.

- The benefit percentage elected will equal no less than $5,000.
- You provide to us written proof from a Doctor that the Covered Person has a Qualifying Event.
- You provide to us written consent for payment from any irrevocable beneficiary and, in community property states, from your spouse.

NOTICE OF CLAIM AND PROOF OF LOSS

You must send us written notice of claim while the Covered Person is living and within 90 days of the date the Qualifying Event is diagnosed. Failure to give notice within 90 days will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of loss. Proof of loss includes information from the Covered Person's Doctor, at your expense, regarding the Covered Person's medical condition. We may require additional information from the Employer in order to verify eligibility. Proof of loss, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). A claim form is available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if the Covered Person is eligible under the terms of this rider. Any second medical opinion may include a physical examination by a Doctor designated by us. In the case of conflicting medical opinions, eligibility will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to the Covered Person and us.

When you request proceeds under this rider, you will be provided with a disclosure demonstrating the effect of the acceleration on the death benefit and Premium, and any other effects on coverage.

BENEFIT PAYMENT

We pay the benefit proceeds to you immediately upon receipt of due written proof of loss. If you are not the current owner of coverage under the Certificate or riders on the date proceeds are requested under this rider, then while you are living the benefit proceeds are payable to the current owner.

For coverage continued by your Spouse after your death or divorce, any benefit proceeds under this rider are payable to your Spouse. If your Spouse is not the current owner of coverage under the Spouse Life Insurance Rider and Children's Life Insurance Rider on the date accelerated death benefit proceeds are requested, then the benefit proceeds are payable to the current owner.

Benefit proceeds received for Terminal Illness will be paid as a lump sum.

For a Qualifying Event other than Terminal Illness, ymay elect to receive the benefit proceeds as a lump sum or in monthly installments. You may elect monthly installments equal to 1-20% of the full amount of the benefit payable under this rider. The minimum monthly installment is $500. Monthly installments are paid once every 30 days until the full accelerated benefit amount has been paid out. Each monthly installment paid will reduce the remaining death benefit by the same amount.

Any payment we make in good faith will discharge our liability to the extent of such payment.

If you or the Covered Person dies after you request proceeds under this rider but before any proceeds are received, then the accelerated death benefit claim will be cancelled and any death benefit will be payable under the terms of the Certificate and riders. If any monthly installments are remaining at the time of death, the remaining amount will be payable as a death benefit under the terms of the Certificate and riders.

EFFECTS ON COVERAGE

When we pay this benefit, coverage is affected in the following ways:

- The Covered Person's Basic and Supplemental Life Insurance amount is reduced by the accelerated death benefit proceeds paid under this rider.
- The Covered Person's life insurance amount that may be converted is reduced by the accelerated death benefit proceeds paid under this rider.
- You will not be eligible to increase the Covered Person's Contributory life insurance amount.
- Premium is reduced based upon the remaining life insurance amount. Such Premium must be paid, unless waived under the Waiver of Premium Rider, to keep the life insurance coverage in force.
- The Covered Person's remaining life insurance amount is subject to future BENEFIT REDUCTIONS, if any, as shown on the SCHEDULE OF BENEFITS in the Certificate or riders.
- You will not be able to reinstate the Covered Person's coverage to its full amount in the event of a recovery from a Qualifying Event.

Payment of accelerated death benefits for a Covered Person will not affect the amount of life insurance on other Covered Persons. If any death benefit remains after payment of the accelerated death benefit, coverage under the AD&D Rider will be unaffected by the payment of an accelerated death benefit.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider or under the AD&D Rider.
- Your Children who are covered under your Children's Life Insurance Rider or under the AD&D Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision of the Employer's prior policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Total Disability,

then life insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

FAMILY AND MEDICAL LEAVE

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of life insurance during an FMLA or State FML Leave of Absence, then coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

SICKNESS OR INJURY

If you are on a Leave of Absence due to your sickness or injury, including Total Disability, then coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 12 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

If the group Policy terminates while your coverage is being continued under this provision due to Total Disability, we will pay the Employee life insurance benefit to the Beneficiary if all of the following conditions are met:

- You are not eligible for waiver of Premium under the Waiver of Premium Rider.
- You have not converted your life insurance coverage to an individual policy.
- We receive Written notice and proof of your Total Disability within 60 days after the group Policy terminates.
- You continue to be Totally Disabled until your death.
- You die, from any cause, within 12 months of the date your Total Disability began.

MILITARY LEAVE

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and applicable state law, then coverage for all Covered Persons may be continued until the date which is 12 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that in effect on the date before the Leave of Absence began.

OTHER LEAVE OF ABSENCE

If you are on a Leave of Absence for any other reason, then coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 3 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.
- The date you become covered under another group life insurance policy as an employee or member.
- The date Premiums are waived under the Waiver of Premium Rider.
- The date the Policy terminates, except as described for Total Disability.
- The date coverage for all Active Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders except as described for Total Disability.

When this continuation ends, other than by waiver of Premium, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your Premium payments are resumed.

CONVERSION FOLLOWING TERMINATION OF CONTINUATION

When continuation under this rider ends other than for nonpayment of Premium or waiver of Premium, and if the Covered Person is not otherwise eligible for insurance under the Policy, then conversion of life insurance will be available as described in the CONVERSION provision of the Certificate and riders.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Active Employees under the Policy, then the terms of the Certificate and riders will apply.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) – FOR TOTAL DISABILITY CLAIMS ONLY

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an "appeal") at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Prior to rendering an adverse decision on appeal, we will provide notice to you of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. We will also notify you if we have new or additional rationale for an adverse appeal determination. We will then provide you with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for your response.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information. If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

TOTAL DISABILITY CONTINUATION RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar total disability continuation provision of the Employer's prior policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION OF RIDER

This rider terminates on the date your life insurance terminates.

TOTAL DISABILITY CONTINUATION

If life insurance for a Covered Person would otherwise end because you are no longer in Active Employment due to Total Disability, and your continuation of insurance under any other rider has ended, then life insurance coverage for all Covered Persons may be continued under the Policy for a limited period of time. During this continued coverage period, the amount of continued life insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums are due during the continuation period on the same basis as on the date before Total Disability began.

Continued life insurance includes the following if effective on the date before your Total Disability began:

- Employee life insurance.
- the Spouse Life Insurance Rider.
- the Children's Life Insurance Rider.
- the Accelerated Death Benefit Rider.
- the AD&D Rider.
- the Waiver of Premium Rider.

Continued life insurance does not include:

- the Portability Rider.
- any other continuation rider(s).

Any rider or coverage that is not eligible for continuation under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment. See the CONVERSION provision of the Certificate and riders for more information about conversion.

Continued insurance is subject to all other terms of the Policy.

CONDITIONS FOR TOTAL DISABILITY CONTINUATION

All of the following conditions must be met in order to continue coverage under this rider:

- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire period your coverage is in force during the continuation period of any rider.
- All Premiums due for life insurance and this rider are paid to us through the date we approve your claim under this rider.

NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY

We must accept your proof of Total Disability in order for this rider to apply. You may request a claim form from the Employer or us in order to submit your proof of Total Disability to us. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s).

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

We will notify the Employer if we approve your claim. We will notify you and the Employer if we deny your claim. If we deny your claim, conversion is available as described in the CONVERSION provision of the Certificate and riders.

If we approve your claim and you had previously converted coverage to an individual policy(ies) when your Active Employment terminated, then the individual policy(ies) must be surrendered without claim (other than refund of Premium) in order for coverage to be continued under this rider. The same coverage(s) that would otherwise end due to your termination of Active Employment may not be both continued under this rider and converted. The Beneficiary for your coverage will be the most recent Beneficiary designated under either the group Policy or the individual conversion policy. See the Certificate and riders for more information about the Beneficiary.

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

If a Covered Person dies while the Policy is in force for Active Employees and all of the following are true:

- You didn't previously submit a claim under this rider, and
- You would otherwise have met the CONDITIONS FOR TOTAL DISABILITY CONTINUATION, and
- Life insurance for the Covered Person would still have been in force under the Policy on the date of the Covered Person's death if a claim under this rider had been approved,

then the Beneficiary can submit a claim for death benefit proceeds along with proof that your Total Disability continued without interruption from the last day you were in Active Employment until the Covered Person's death. Any Premiums that would have been due for continued coverage must be paid.

TERMINATION OF TOTAL DISABILITY CONTINUATION

Continued coverage under this rider will stop on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.
- Your 65th birthday; however, the continuation period will not be less than 6 months while the Policy is in force for Active Employees.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date the Policy terminates, except as provided in the EXTENSION AFTER POLICY TERMINATION provision.
- The date coverage for all Active Employees under the Policy terminates.
- For your Spouse and Children's coverage, the date that person's life insurance would otherwise end according to the terms of the rider(s).

If coverage is no longer continued under this rider, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are continued.

The amount of insurance will be subject to the Certificate and riders in effect on the date you become eligible as an Active Employee.

CONVERSION FOLLOWING TERMINATION OF TOTAL DISABILITY CONTINUATION

When continued coverage under this rider ends other than for nonpayment of Premium, and if the Covered Person is not otherwise eligible for insurance under the Policy, then conversion will be available as described in the CONVERSION provision of the Certificate and riders.

EXTENSION AFTER POLICY TERMINATION

If the group Policy terminates while your coverage is being continued due to Total Disability, we will pay the Employee life insurance benefit to the Beneficiary if all of the following conditions are met:

- You are not eligible for waiver of Premium under the Waiver of Premium Rider.
- You have not converted your life insurance coverage to an individual policy.
- You continue to be Totally Disabled until your death.
- You die, from any cause, within 12 months of the date your Total Disability began.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an "appeal") at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

Prior to rendering an adverse decision on appeal, we will provide notice to you of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. We will also notify you if we have new or additional rationale for an adverse appeal determination. We will then provide you with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for your response.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

PORTABILITY RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider or under the AD&D Rider.
- Your Children who are covered under your Children's Life Insurance Rider or under the AD&D Rider.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER
This rider terminates on the earliest of the following:
- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

This rider will not terminate while your coverage is being continued under the terms of this rider.

PORTABILITY

If there are any Covered Persons on portability under this rider when the Policy would otherwise terminate, the Policy will remain in force to cover those Covered Persons on portability until the date there are no Covered Persons on portability.

EMPLOYEE PORTABILITY

Portability means you can apply to continue coverage under the same Policy after it would otherwise terminate, if certain conditions are met. Continued coverage under this rider includes the following:

- Employee life insurance under the Certificate
- Spouse life insurance under the Spouse Life Insurance Rider, if Employee life insurance is also continued
- Children's life insurance under the Children's Life Insurance Rider, if Employee life insurance is also continued
- Employee AD&D insurance under the AD&D Rider, if Employee life insurance is also continued
- Spouse AD&D insurance under the AD&D Rider, if Employee AD&D insurance is also continued
- Children's AD&D insurance under the AD&D Rider, if Employee AD&D insurance is also continued
- Coverage under all riders except the Waiver of Premium Rider and any Continuation riders

CONDITIONS FOR EMPLOYEE PORTABILITY

All of the following conditions must be met:

- You must apply for a minimum of $5,000 in continued Employee coverage.
- If you apply for portability of Spouse coverage, you must apply for a minimum of $5,000 in continued Spouse coverage.
- If you apply for portability of Children's coverage, you must apply for a minimum of $1,000 in continued Children's coverage.
- You have not applied for conversion of life insurance on the same amounts.
- You apply for portability before the date you attain age 69.
- You apply for portability within 31 days of the date your Supplemental life insurance coverage would otherwise terminate due to any of the following:
  - You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Active Employees.
  - The Policyholder terminates coverage under the Policy for all Active Employees, and does not replace it with another life insurance plan.
  - You are no longer in an eligible class for coverage under the Policy.
  - Any other continuation provided under the Policy ends.

You will be given notice of your portability and conversion rights at least 15 days before the date any part of your life insurance ends. Your portability rights will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your portability rights extend beyond 60 days after the expiration of the conversion period.

Portability is not available for any of the following:

- Any amounts of life insurance for which a conversion application has been received by us.
- Coverage that reduces due to BENEFIT REDUCTIONS as described on the SCHEDULE OF BENEFITS in the Certificate or any riders.
- Coverage that reduces due to your change from one eligible class to another.
- Coverage that reduces due to a Policy change.
- Coverage that is being continued under the Waiver of Premium Rider.
- Coverage that ends due to termination under the Waiver of Premium Rider.

You may apply for conversion of any terminating life insurance amounts that are not eligible for portability. See the CONVERSION provision of the Certificate and riders.

APPLICATION FOR EMPLOYEE PORTABILITY

You may apply for portability on the same amount of insurance that would otherwise terminate or a lesser amount according to the available amounts on the portability application. You must apply for portability of your insurance in order to continue Spouse and Children's insurance. The amount(s) that can be continued under this rider are subject to the following maximum(s):

- The lesser of 5 times your Basic Yearly Earnings or $750,000 total Employee life insurance
- $250,000 total Employee life insurance if you are age 65 or older
- $750,000 total Employee AD&D insurance
- $250,000 total Spouse life insurance, but not to exceed the total amount of Employee life insurance continued
- $750,000 total Spouse AD&D insurance
- $25,000 total Children's life insurance, but not to exceed the total amount of Employee life insurance continued
- $50,000 total Children's AD&D insurance

You may apply for conversion of any terminating life insurance amounts that exceed the maximum amount(s) eligible for portability. See the CONVERSION provision of the Certificate and riders. You will not be eligible to increase the ported coverage amount(s). Ported coverage is subject to all the terms of the Policy including BENEFIT REDUCTIONS as described on the SCHEDULE OF BENEFITS in the Certificate or any riders.

If you die within 31 days of the date you become eligible for portability under this rider (the "conversion period"), any life insurance amount that you were entitled to convert will be payable according to the CONVERSION provision of the Certificate and riders. If your Spouse or Child dies during the conversion period, any Spouse or Children's life insurance amount that you were entitled to convert will be payable according to the CONVERSION provision of your Spouse Life Insurance Rider or Children's Life Insurance Rider. Any AD&D insurance amount you are eligible to port will be payable according to the AD&D Rider. Any unearned Premiums paid for portability will be refunded to the Beneficiary.

You do not need to provide Evidence of Insurability in order to apply for portability. You may complete the Evidence of Insurability section of the application if you want to request a lower portability Premium rate. If we accept your application for portability but decline any Evidence of Insurability, you may either pay the standard portability Premium rate or apply for conversion of life insurance within 31 days of the date we provide you written notice of conversion. See the CONVERSION provision of the Certificate and riders. Your coverage must be ported under the terms of this rider in order for Spouse or Children's coverage to be ported.

Your application for portability must be approved by us. When we approve your application, ported coverage under this rider will be effective on the day after the conversion period ends. Premiums under this rider will be billed directly to you on a quarterly basis. Each quarterly Premium due will include a billing fee as indicated on the portability application or subsequent notice. Continued Premium payment is required to keep coverage in force. The initial Premium will be based on the portability Premium rates in effect at the time you apply for portability. We may change the portability Premium rates at any time upon 90 days written notice to you.

If you have made an absolute assignment of your insurance, only the current owner may apply for portability.

MISSTATEMENT OF EVIDENCE OF INSURABILITY FOR EMPLOYEE PORTABILITY

If your or your Spouse's Premium rates are based on Evidence of Insurability as provided on your application for portability, and you or your Spouse have misstated any information requested on the application for portability such that the lower Premium rates would not have been approved by us, then we will adjust your or your Spouse's Premium to the standard portability Premium rates. Any back Premium due as a result of this adjustment will be required. We will not adjust your or your Spouse's Premium after coverage has been continued under this rider for two years during your or your Spouse's lifetime.

GRACE PERIOD FOR EMPLOYEE PORTABILITY

You have a grace period of 31 days for the payment of any Premium due. During the grace period coverage will remain in force. If full Premium payment is not received by us by the due date, we will give written notification to you that if the Premium is not paid by the end of the grace period then all coverage will end on the last day of the grace period. If we fail to give such written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving written notice of such intent to you, and such notice will specify the date all coverage will terminate if the Premium remains unpaid. You are required to pay a pro rate Premium for any period

coverage was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which coverage was in effect and Premium was not paid.

TERMINATION OF EMPLOYEE PORTABILITY

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you attain age 70.
- The date you die.
- The date we approve a claim under the Waiver of Premium Rider.

You may apply for conversion of any life insurance amount(s) that terminate when portability under this rider ends, other than for nonpayment of Premium or at your death. Your surviving Spouse and Children may apply for conversion of any Spouse and Children's life insurance amount(s) that terminate when you die. See the CONVERSION provision of the Certificate and riders.

Any unearned Premiums paid for ported coverage will be refunded.

PORTABILITY AT DEATH OR DIVORCE

If you die, your Spouse can apply to continue coverage under the same Policy if certain conditions are met. Continued coverage following your death includes the following:

- Spouse life insurance under the Spouse Life Insurance Rider
- Children's life insurance under the Children's Life Insurance Rider
- Spouse AD&D insurance under the AD&D Rider, if Spouse life insurance is also continued
- Children's AD&D insurance under the AD&D Rider, if Children's life insurance is also continued

If you divorce, your Spouse can apply to continue coverage under the same Policy if certain conditions are met. Your Spouse's continued coverage following divorce includes the following:

- Spouse life insurance under the Spouse Life Insurance Rider
- Spouse AD&D insurance under the AD&D Rider, if Spouse life insurance is also continued

For purposes of this rider, "divorce" includes annulment.

CONDITIONS FOR PORTABILITY AT DEATH OR DIVORCE

All of the following conditions must be met:

- Your Spouse must have been insured under your Spouse Life Insurance Rider on the date of your death or divorce.
- Your Spouse must apply for portability before the date your Spouse attains age 60.
- Your Spouse must apply for portability within 31 days of your death or divorce.

Your Spouse will be given notice of portability and conversion rights when your Spouse's life insurance ends due to death or divorce. Your Spouse's portability rights will expire on the later of 16 days after your Spouse is given such notice or the end of the conversion period, but in no event will your Spouse's portability rights extend beyond 60 days after the expiration of the conversion period.

Children may be covered following your death only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

Conversion is available for any terminating life insurance amount(s) that are not eligible for portability. See the CONVERSION provision of the riders. Any amounts of life insurance for which an application for conversion has been received by us are not eligible for portability under this rider.

APPLICATION FOR PORTABILITY AT DEATH OR DIVORCE

Your Spouse may apply for portability of the same amount of insurance that would otherwise terminate or a lesser amount according to the available amounts on the portability application. Your Spouse must apply for portability of Spouse insurance in order to continue Children's insurance. Your Spouse may only apply for portability of Children's Insurance in the event of your death. The amount(s) that can be continued under this provision are subject to the following maximum(s):

- $250,000 total Spouse life insurance
- $750,000 total Spouse AD&D insurance
- $25,000 total Children's life insurance, but not to exceed the total amount of Spouse life insurance continued
- $50,000 total Children's AD&D insurance

Conversion is available for any life insurance amounts that exceed the maximum amount(s) eligible for portability under this provision. See the CONVERSION provision of the riders. Your Spouse will not be eligible to increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy, Certificate and any riders.

If your Spouse dies within 31 days of the date your Spouse becomes eligible for portability under this provision (the "conversion period"), any Spouse life insurance amount that was eligible for conversion will be payable according to the CONVERSION provision of the Spouse Life Insurance Rider. If your Child dies during the conversion period, any Children's life insurance amount that was eligible for conversion on that Child will be payable according to the CONVERSION provision of the Children's Life Insurance Rider. Any AD&D insurance amount your Spouse is eligible to port will be payable according to the AD&D Rider. Any unearned Premiums paid for portability will be refunded to the Beneficiary.

Your Spouse does not need to provide Evidence of Insurability in order to apply for portability. Your Spouse may complete the Evidence of Insurability section of the application if your Spouse wants to request a lower portability Premium rate. If we accept your Spouse's application for portability but decline your Spouse's Evidence of Insurability, your Spouse may either pay the standard portability Premium rate or apply for conversion of life insurance within 31 days of the date we provide your Spouse written notice of conversion. See the CONVERSION provision of the riders. Spouse coverage must be ported under the terms of this rider in order for Children's coverage to be ported.

If we approve your Spouse's application for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under your Spouse Life Insurance Rider. If Children's coverage is ported after your death, your Spouse will also become the owner of the Children's coverage that was previously provided under your Children's Life Insurance Rider. Ported coverage under this provision will be effective on the day after the conversion period ends. Premiums under this provision will be billed directly to your Spouse on a quarterly basis. Each quarterly Premium due will include a billing fee as indicated on the portability application or subsequent notice. Continued Premium payment is required to keep coverage in force. The initial Premium will be based on the portability Premium rates in effect at the time your Spouse applies for portability. We may change the portability Premium rates at any time upon 90 days written notice to your Spouse.

If you have made an absolute assignment of your insurance, the current owner's rights under the Policy will terminate on the date of your death. The current owner's rights regarding your Spouse's insurance will terminate on the date of your divorce. Your Spouse as the new owner under this provision may make an absolute assignment of insurance, as described in the ASSIGNMENT provision of the Certificate.

BENEFICIARY FOR PORTABILITY AT DEATH OR DIVORCE

For coverage continued under this provision, the Beneficiary is named by your Spouse to receive any proceeds payable at your Spouse's death. While your Spouse's coverage is in force under this provision, your Spouse may change the Beneficiary by Written request on a form that is acceptable to us. A Beneficiary designation form is available from us. An accepted designation will take effect as of the date it is Signed but will not affect any payment we make or action we take before receiving the Signed form. If your Spouse has made an absolute assignment of insurance, only the current owner may change the Beneficiary designation for proceeds payable at your Spouse's death.

If an irrevocable Beneficiary is named for proceeds payable at your Spouse's death, the Beneficiary designation can only be changed with the consent of the irrevocable Beneficiary.

There can be one or more Beneficiaries for proceeds payable at your Spouse's death. If two or more Beneficiaries are named and their shares are not specified in the Beneficiary designation, then the Beneficiaries will share any insurance proceeds equally. If a primary Beneficiary does not survive your Spouse, their share will be payable to the remaining primary Beneficiaries. One or more contingent Beneficiaries may be named to receive the proceeds in the event that all of the primary Beneficiaries named do not survive your Spouse.

Your Spouse is the Beneficiary for all other proceeds payable. This Beneficiary designation may not be changed. If your Spouse has made an absolute assignment of insurance, then during your Spouse's lifetime those proceeds are payable to the current owner.

PAYMENT OF PROCEEDS FOR PORTABILITY AT DEATH OR DIVORCE

For coverage continued under this provision, a Spouse death benefit is payable if your Spouse dies while the Spouse Life Insurance Rider is in force. Other benefits are payable if a covered loss occurs while coverage is in force, and while your Spouse is living. See the CONVERSION provision of the Children's Life Insurance Rider for information about death benefits payable during the conversion period following your Spouse's death.

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Spouse's or Child's death or loss under any rider. **Exception:** If your Child dies during the conversion period following your Spouse's death and your Spouse would otherwise have been the Beneficiary, we will pay the Child death benefit proceeds to your Spouse's estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate. If there is no eligible Beneficiary, we will pay the proceeds to your Spouse's estate.

MISSTATEMENT OF EVIDENCE OF INSURABILITY FOR PORTABILITY AT DEATH OR DIVORCE

If your Spouse's Premium rates are based on Evidence of Insurability as provided on your Spouse's application for portability, and your Spouse has misstated any information requested on the application for portability such that the lower Premium rates would not have been approved by us, then we will adjust your Spouse's Premium to the standard portability Premium rates. Any back Premium due as a result of this adjustment will be required. We will not adjust your Spouse's Premium after coverage has been continued under this rider for two years during your Spouse's lifetime.

GRACE PERIOD FOR PORTABILITY AT DEATH OR DIVORCE

Your Spouse has a grace period of 31 days for the payment of any Premium due. During the grace period coverage will remain in force. If full Premium payment is not received by us by the due date, we will give written notification to your Spouse that if the Premium is not paid by the end of the grace period then all coverage will end on the last day of the grace period. If we fail to give such written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving written notice of such intent to your Spouse, and such notice will specify the date all coverage will terminate if the Premium remains unpaid. Your Spouse is required to pay a pro rate Premium for any period coverage was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which coverage was in effect and Premium was not paid.

TERMINATION OF PORTABILITY AT DEATH OR DIVORCE

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date your Spouse attains age 70.
- The date your Spouse dies.
- For each Child's coverage, the date the Child is no longer an eligible Child as defined by the Children's Life Insurance Rider. Coverage of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.
- For Children's coverage, the date there are no longer any eligible Children covered under the Children's Life Insurance Rider.

If your Spouse is continuing coverage under this provision and then later your Spouse becomes eligible as an Active Employee under the Policy, then any amount(s) of coverage continued under this rider will be reduced by the amount(s) of coverage your Spouse has as an Active Employee. Any unearned Premiums paid for ported coverage will be refunded.

CONVERSION FOR TERMINATION OF PORTABILITY AT DEATH OR DIVORCE

Your Spouse may convert any life insurance amounts that stop when portability under this provision ends for any reason other than nonpayment of Premium, or your Spouse's death, or your Child reaching the termination age under the Children's Life Insurance Rider. Conversion is also available for any part of Spouse life insurance that reduces due to a BENEFIT REDUCTION as described on the SCHEDULE OF BENEFITS of any rider or a Policy change. Conversion is also available for any part of Children's life insurance that reduces due to a Policy change. See the CONVERSION provision of the rider(s). If your Spouse has made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Child may convert any Children's life insurance amount that stops under the Children's Life Insurance Rider due to your Child reaching the termination age under that rider, or when portability under this rider ends due to your Spouse's death. If a Child is too young to contract for life insurance after your Spouse's death, then a parent or a court-appointed guardian of the Child may apply for conversion of that Child's coverage. See the CONVERSION provision of the rider.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

Applicable only to Associates who have Spouse and/or Children's AD&D insurance in addition to Spouse and Children's life insurance

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

BASIC EMPLOYEE AD&D INSURANCE
Basic Employee AD&D insurance is Noncontributory by Employees.

Eligible Class(es)	Full Amount
All Eligible Associates	Equal to the amount of Basic Employee life insurance

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF BASIC EMPLOYEE AD&D INSURANCE FOR CLASS 1 ASSOCIATES WHO ARE CLASSIFIED AS VICE PRESIDENT AND ABOVE
$500,000

MAXIMUM AMOUNT OF BASIC EMPLOYEE AD&D INSURANCE FOR CLASS 2 ALL OTHER ASSOCIATES
$250,000

The Basic Employee AD&D insurance amount will not exceed the Basic Employee life insurance amount in force.

SUPPLEMENTAL EMPLOYEE AD&D INSURANCE

Supplemental Employee AD&D insurance is Contributory by Employees.

Eligible Class(es)	Full Amount
All Eligible Associates	Choice of 1, 2, 3, 4, 5, 6 or 7 times your Basic Yearly Earnings, with a minimum of $20,000

An insurance amount that does not equal an increment of $10,000 is rounded to the next higher $10,000.

MAXIMUM AMOUNT OF SUPPLEMENTAL EMPLOYEE AD&D INSURANCE FOR ALL ELIGIBLE ASSOCIATES

$2,000,000

EMPLOYEE BENEFIT REDUCTIONS FOR ALL ELIGIBLE ASSOCIATES

Basic Employee AD&D insurance

Your insurance amount will decrease as follows:

- To 65% of the original amount on the Policy anniversary that is on or next follows your 65th birthday.
- To 45% of the original amount on the Policy anniversary that is on or next follows your 70th birthday.
- To 30% of the original amount on the Policy anniversary that is on or next follows your 75th birthday.
- To 20% of the original amount on the Policy anniversary that is on or next follows your 80th birthday.
- To 15% of the original amount on the Policy anniversary that is on or next follows your 85th birthday.

Reduced insurance amounts are not rounded.

SUPPLEMENTAL SPOUSE AD&D INSURANCE

Supplemental Spouse AD&D insurance is Contributory by Employees.

Eligible Class(es)	Full Amount
Spouse only	50% of Employee Supplemental AD&D amount
Spouse when child(ren) are also covered	40% of Employee Supplemental AD&D amount

MAXIMUM AMOUNT OF SUPPLEMENTAL SPOUSE AD&D INSURANCE

$1,000,000

SUPPLEMENTAL CHILDREN'S AD&D INSURANCE

Supplemental Children's AD&D insurance is Contributory by Employees.

Eligible Class(es)	Full Amount
Child(ren) only	15% of Employee Supplemental AD&D amount
Child(ren) when Spouse also covered	10% of Employee Supplemental AD&D amount

MAXIMUM AMOUNT OF SUPPLEMENTAL CHILDREN'S AD&D INSURANCE

$50,000

ACCIDENTAL DEATH BENEFIT

For:	Benefit Amount:
Loss of life	Full Amount of AD&D insurance

ACCIDENTAL DISMEMBERMENT BENEFITS

For:	Benefit Amount:
Loss of an Arm	50% of the Full Amount of AD&D insurance
Loss of a Leg	50% of the Full Amount of AD&D insurance
Loss of a Hand	50% of the Full Amount of AD&D insurance
Loss of a Foot	50% of the Full Amount of AD&D insurance
Loss of a Finger	5% of the Full Amount of AD&D insurance to a maximum of $100 per finger
Loss of a Toe	5% of the Full Amount of AD&D insurance to a maximum of $100 per toe

OTHER ACCIDENTAL LOSS BENEFITS

For:	Benefit Amount:
Loss of Sight in both eyes	100% of the Full Amount of AD&D insurance
Loss of Sight in one eye	50% of the Full Amount of AD&D insurance
Loss of Speech	50% of the Full Amount of AD&D insurance
Loss of Hearing	50% of the Full Amount of AD&D insurance
Paralysis of all four limbs	100% of the Full Amount of AD&D insurance
Paralysis of three limbs	75% of the Full Amount of AD&D insurance
Paralysis of two limbs	75% of the Full Amount of AD&D insurance
Paralysis of one limb	25% of the Full Amount of AD&D insurance
Brain Damage	25% of the Full Amount of AD&D insurance to a maximum of $25,000
Coma	20% of the Full Amount of AD&D insurance to a maximum of $50,000
Burn Disfigurement	25% of the Full Amount of AD&D insurance to a maximum of $25,000
HIV	25% of the Full Amount of AD&D insurance to a maximum of $50,000

Only one Full Amount is payable for any combination of the losses listed above per Covered Person. For example: if the Covered Person has a loss for which the Benefit Amount paid was 50% of the Full Amount of that Covered Person's AD&D insurance, then the Benefit Amount for that Covered Person's next loss will be no more than 50% of the Full Amount.

ADDITIONAL ACCIDENT BENEFITS

Benefit:	Additional Amount:
Common Carrier	Equal to 100% of the full Benefit Amount for the loss to a maximum of $500,000
Safety Belt use	Equal to 25% of the full Benefit Amount for loss of life to a maximum of $25,000
Airbag use	Equal to 10% of the full Benefit Amount for loss of life to a maximum of $5,000
Transportation/Repatriation	Equal to 2% of the full Benefit Amount for loss of life to a maximum of $2,000

Child Care (per child)	Equal to 12% of the full Benefit Amount for loss of life annually up to a total of $10,000 for all children
Child education (per student)	Equal to 20% of the full Benefit Amount for loss of life up to a total of $10,000 for all students
Spouse education	Equal to 3% of the full Benefit Amount for loss of life up to a total of $5,000 per academic year for up to 4 years
Elder care	Equal to 5% of the full Benefit Amount for loss of life to a maximum of $20,000
Occupational assault	Equal to 100% of the full Benefit Amount for the loss to a maximum of $10,000
Felonious assault	Equal to 20% of the full Benefit Amount for the loss to a maximum of $20,000

DEFINITIONS

Accidental Injury means a bodily injury sustained by a Covered Person, which is a direct result of an accident, independent of disease or bodily or mental illness or infirmity or any other cause, and which occurs while the Covered Person's insurance under this rider is in force. Accidental Injury includes bodily injury caused by exposure to the elements when the exposure is a direct result of an accident.

Airbag means a passenger restraint system properly installed in the Automobile in which the Covered Person was riding at the time of the Accidental Injury, which inflates for added protection to the head and chest areas.

Automobile means any self-propelled private passenger vehicle which has four or more tires and which is not being used for commercial purposes.

Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material duties of everyday life, as determined by a Doctor.

Burn Disfigurement means damage to the skin or other body parts resulting in permanent scarring on at least 5% of the body, resulting from extreme heat, flame, contact with heated objects, or chemicals.

Child Care means any facility or private care that:
- is licensed as child care by the state,
- provides non-medical care and supervision for children, and
- is not operated by you or a member of your immediate family.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused, as determined by a Doctor, and which continues for a period of 30 days.

Common Carrier means any commercial transportation that operates on a regularly scheduled basis between predetermined points or cities, and the public conveyance is operated by and licensed for passenger service.

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered for Supplemental coverage under the Spouse Life Insurance Rider and is enrolled for Contributory Spouse coverage under this rider.
- Your Children who are covered for Supplemental coverage under the Children's Life Insurance Rider and are enrolled for Contributory Children's coverage under this rider.

For benefits other than death, this includes your Children from the date of birth.

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Loss of a Finger means the finger is permanently severed from the body through or above the metacarpophalangeal joints (i.e. the third joint from the tip of the finger or the second joint from the tip of the thumb) but below the wrist. See "Loss of a Hand" for loss of the thumb and index finger of the same hand.

Loss of a Foot means the foot is permanently severed from the body at or above the ankle but below the knee.

Loss of a Hand means the hand is permanently severed from the body at or above the wrist, but below the elbow. Loss of a Hand includes loss of the thumb and index finger of the same hand where the thumb and index finger are permanently severed through or above the metacarpophalangeal joints (i.e. the third joint from the tip of the finger or the second joint from the tip of the thumb).

Loss of a Leg means the leg is permanently severed from the body at or above the knee.

Loss of a Toe means the toe is permanently severed from the body at or above the metatarsophalangeal joints but below the ankle.

Loss of an Arm means the arm is permanently severed from the body at or above the elbow.

Loss of Hearing means the entire and irrevocable loss of hearing in both ears, as determined by a Doctor.

Loss of Sight means permanent and uncorrectable loss of sight in an eye, as determined by a Doctor. The visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.

Loss of Speech means the entire and irrevocable loss of speech as determined by a Doctor.

Paralysis means the total impairment of voluntary movement and sensory function of a limb (arm or leg), without severance, and the paralysis is determined by a Doctor to be permanent, complete and irreversible.

Safety Belt means a passenger restraint system properly installed in the Automobile in which the Covered Person was riding at the time of the Accidental Injury, which consists of a belt or strap.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

ENROLLMENT

If you are eligible for AD&D coverage, you must enroll for Contributory AD&D coverage before Contributory coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and you were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory AD&D coverage that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EFFECTIVE DATE

For Noncontributory coverage, each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage.

For Contributory coverage, each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date the Covered Person is eligible for coverage, if you enroll for coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for coverage.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when the Covered Person's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once AD&D coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The first day of the month that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.

Any decrease in coverage other than benefit reductions noted on the SCHEDULE OF BENEFITS will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The end of the period for which Premiums for this rider are paid if the next Premium is not paid by its due date, subject to the Policy's grace period.
- The date you voluntarily cancel this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The date you retire from Active Employment with the Employer.
- For your Spouse's coverage, the date the Spouse Life Insurance Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Life Insurance Rider terminates.
- For your Spouse's coverage, the date you voluntarily cancel Contributory Spouse AD&D coverage under this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- For your Children's coverage, the date you voluntarily cancel Contributory Children's AD&D coverage under this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The date a claim is approved under the Waiver of Premium Rider.

Termination will not prejudice the payment of benefits for a covered loss caused by an Accidental Injury that occurs while the Covered Person is insured under this rider.

CONVERSION

When coverage under this rider terminates, conversion of AD&D coverage to an individual policy is not available.

INCONTESTABILITY

Any statement made by you or your Spouse or Child is considered a representation and not a warranty. We will not use such statement to contest insurance under this rider after it has been in force for two years during the Covered Person's lifetime. We will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during the Covered Person's lifetime.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

AD&D BENEFITS

We pay an AD&D benefit if we receive Written proof that a Covered Person suffered a covered loss (as described below) as the result of an Accidental Injury. The Covered Person must be insured under this rider on the date of the Accidental Injury, and the cause of the loss must not be excluded. The AD&D benefit is the amount for the eligible class and for the loss as shown on the SCHEDULE OF BENEFITS in effect on the date of the Accidental Injury.

If any benefit described below indicates that it is payable to you if living, and you are not the current owner of coverage under the Certificate or riders on the date of the loss, then those benefit proceeds are payable to the current owner. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death or divorce.

Accidental Death

A benefit is payable to the Beneficiary if an Accidental Injury causes a Covered Person's death within 365 days of the Accidental Injury. See the Certificate and riders for more information about the Beneficiary.

We will presume that the Covered Person died as a result of Accidental Injury if all of the following are true:

- The conveyance in which the Covered Person was traveling (including but not limited to an automobile, airplane, ship or train) disappears, sinks or is wrecked.
- The body of the Covered Person is not found.
- A reasonable period of time, but not more than 365 days has elapsed from the later of the date the conveyance was scheduled to arrive at its destination or the date the Covered Person was reported missing to the authorities.

If we pay an Accidental Death benefit due to the Covered Person's disappearance and it is later found that the Covered Person is alive, the benefits paid must be refunded to us.

Accidental Dismemberment

A benefit is payable if an Accidental Injury causes a Covered Person's loss of a covered finger, toe, limb or appendage within 365 days of the Accidental Injury. The types of and benefit amounts for covered Accidental Dismemberment losses are shown on the SCHEDULE OF BENEFITS. Accidental Dismemberment benefits are payable to you if living, otherwise to the Beneficiary.

If Accidental Injury causes more than one loss to the same covered digit, limb or appendage, only the largest benefit for the loss will be payable.

Other Accidental Loss

A benefit is payable if an Accidental Injury causes a Covered Person's loss as described below. The benefit amounts for these covered losses are shown on the SCHEDULE OF BENEFITS. These benefits are payable to you if living, otherwise to the Beneficiary.

Loss of Sight: The Covered Person has a Loss of Sight in one or both eyes, and the Loss of Sight is continuous for 180 days following the date the Loss of Sight began. Loss of Sight must be diagnosed within 180 days of the Accidental Injury.

Loss of Speech: The Covered Person has a Loss of Speech that is continuous for 180 days following the date the Loss of Speech began. Loss of Speech must be diagnosed within 180 days of the Accidental Injury.

Loss of Hearing: The Covered Person has a Loss of Hearing in both ears, and the Loss of Hearing is continuous for 180 days following the date the Loss of Hearing began. Loss of Hearing must be diagnosed within 180 days of the Accidental Injury.

Paralysis: The Covered Person has Paralysis of one or more limbs. Only one Paralysis benefit is payable per Accidental Injury. Paralysis must be diagnosed within 180 days of the Accidental Injury.

Brain Damage: The Covered Person has Brain Damage that is continuous for 30 days following the date the Brain Damage began. Brain Damage must be diagnosed within 180 days of the Accidental Injury. If both a Brain Damage benefit and a Coma benefit would be otherwise payable due to the same Accidental Injury, then only the larger of the two benefits will be payable.

Coma: The Covered Person is in a Coma that is continuous for 30 days following the date the Coma began. A Coma must be diagnosed within 180 days of the Accidental Injury. If both a Coma benefit and a Brain Damage benefit would be otherwise payable due to the same Accidental Injury, then only the larger of the two benefits will be payable.

Burn Disfigurement: The Covered Person has Burn Disfigurement.

HIV: You contract the Human Immunodeficiency Virus (HIV) as a result of an Accidental Injury sustained while you were performing assigned duties of your employment with the Employer. You must submit a workers' compensation injury report and an initial negative blood test for HIV to the Employer within 72 hours of the Accidental Injury, and you must subsequently test positive for HIV within 6 months of the Accidental Injury. All tests to determine the presence of HIV must be conducted by a Doctor. No HIV benefit is payable for your insured Spouse's or Child's loss.

Additional Accident Benefits

When a benefit is payable under this rider for Accidental Death, Accidental Dismemberment or Other Accidental Loss, an Additional Accident Benefit may be payable under the terms described below. The additional benefit amounts are shown on the SCHEDULE OF BENEFITS. These benefits are payable to you if living, otherwise to the Beneficiary.

Common Carrier: The Accidental Injury occurs while the Covered Person is traveling as a passenger in or on a public conveyance classified as a Common Carrier, including entering into or departing from the Common Carrier. A passenger does not include a person who is performing duties for the Common Carrier as part of their employment.

Safety Belt use: The Accidental Injury causing death occurs while the Covered Person is riding in an Automobile equipped with Safety Belts, and the Covered Person was wearing a properly fastened Safety Belt at the time of the Accidental Injury.

If the accident report or other accident records can't verify the Safety Belt use, and payment of this benefit would not otherwise be excluded, then a flat benefit amount of $1,000 is payable.

This benefit is not payable if the death was caused or contributed to by any use of intoxicating liquors, marijuana, narcotic drugs, depressants or similar substances, whether or not prescribed by a Doctor, by the Covered Person or by the driver of the Automobile in which the Covered Person was riding.

Airbag use: The Accidental Injury causing death occurs while the Covered Person is riding in an Automobile equipped with an Airbag for the Covered Person's seat in which the Airbag for the Covered Person's seat operated properly upon impact at the time of the Accidental Injury. The Covered Person must also have been wearing a properly fastened Safety Belt at the time of the Accidental Injury.

If the accident report or other accident records can't verify the Airbag use, and payment of this benefit would not otherwise be excluded, then a flat benefit amount of $1,000 is payable.

This benefit is not payable if the death was caused or contributed to by any use of intoxicating liquors, marijuana, narcotic drugs, depressants or similar substances, whether or not prescribed by a Doctor, by the Covered Person or by the driver of the Automobile in which the Covered Person was riding.

Transportation/Repatriation: The Covered Person's accidental death occurs at least 100 miles from the Covered Person's primary residence.

Child Care: Your dependent child under age 13 is enrolled in Child Care within 31 days of the date of a Covered Person's death for which a benefit is payable under this rider. No Child Care benefit is payable for your insured Spouse's or Child's death. You or the Beneficiary must provide proof annually that your child remains eligible. Benefits will stop when your child is no longer eligible.

If you do not have an eligible dependent child, a flat benefit amount of $1,000 is payable.

Child education: Your dependent child is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of a Covered Person's death for which a benefit is payable under this rider. No child education benefit is payable for your insured Spouse's or Child's death. To be considered full-time, your child's full-time school attendance must be 6 months or more in each annual period following enrollment. Benefits are payable at the end of each annual period following enrollment. You or the Beneficiary must provide proof annually that your child remains eligible. Benefits will stop when your child is no longer eligible.

A dependent child for this benefit has the same meaning as a Child under the Children's Life Insurance Rider.

If you do not have an eligible dependent child, a flat benefit amount of $1,000 is payable.

Spouse education: Your spouse is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of your death for which a benefit is payable under this rider. No spouse education benefit is payable for your insured Spouse's or Child's death. To be considered full-time, your spouse's full-time school attendance must be 6 months or more in each annual period following enrollment. Benefits are payable at the end of each annual period following enrollment. The Beneficiary must provide proof annually that your spouse remains eligible. Benefits will stop when your spouse is no longer eligible.

A spouse for this benefit has the same meaning as a Spouse under the Spouse Life Insurance Rider.

If you do not have an eligible spouse, a flat benefit amount of $1,000 is payable.

Elder care: A relative age 60 or older is dependent on the Covered Person for support and maintenance at the time of the Covered Person's death, and either resided with the Covered Person or incurred expenses for a nursing home or home health care which were partially or fully paid by the Covered Person. Only one elder care benefit is payable under this rider. No elder care benefit is payable for your insured Spouse's or Child's death. You or the Beneficiary must provide proof of an eligible relative in order to receive this benefit.

A relative for this benefit means your spouse, your sibling, your parent, your grandparent, or the sibling, parent, or grandparent of your spouse. A spouse for this benefit has the same meaning as a Spouse under the Spouse Life Insurance Rider.

If the Covered Person does not have an eligible relative, a flat benefit amount of $1,000 is payable.

Occupational assault: Your loss for which a benefit is payable under this rider is the result of an intentional and unlawful act of physical violence directed at you by another person while you were performing assigned duties of your employment with the Employer. A report of criminal activity must be filed by you or on your behalf with the appropriate law enforcement authority within 48 hours of the assault. No occupational assault benefit is payable for your insured Spouse's or Child's loss. If an occupational assault benefit and a felonious assault benefit would be otherwise payable for the same loss, then only the larger of the benefits will be payable.

Felonious assault: Your loss for which a benefit is payable under this rider is the result of a violent or criminal act directed at you by another person during the course of or attempt at robbery or hold-up, or a kidnapping involving Policyholder funds. No felonious assault benefit is payable for your insured Spouse's or Child's loss. If a felonious assault benefit and an occupational assault benefit would be otherwise payable for the same loss, then only the larger of the benefits will be payable.

NOTICE OF CLAIM AND PROOF OF LOSS

You or the Beneficiary must send us Written notice of claim within 90 days after the date of loss. Failure to give notice within 90 days will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of loss. Proof of loss for a death claim consists of a certified copy of the Covered Person's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds. Proof of loss for any other claim consists of information from the Covered Person's Doctor, at your expense, regarding the Covered Person's loss that is covered under this rider. We may require additional information from the Employer in order to verify eligibility. Proof of loss, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). A claim form is available from the Employer or us.

We will review proof of loss we receive in order to determine our liability and the correct payee(s).

PHYSICAL EXAMINATION

We may require the Covered Person to be examined, at our expense, by one or more Doctors or other medical practitioners of our choice. We can require an examination as often as it is reasonable to do so for the duration of a claim.

PAYMENT OF PROCEEDS

If the Beneficiary is not living on the date payment is made, benefits are payable to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) - APPLICABLE TO ALL OTHER CLAIMS

Refer to the Certificate provision.

EXCLUSIONS

Benefits under this rider are not payable for any loss caused or contributed to by any of the following:

- Suicide or attempted suicide, or intentionally self-inflicted injury, regardless of mental capacity.
- Disease or infirmity of mind or body, or medical and surgical treatment for such disease or infirmity.
- An infection, other than an infection that is a direct result or consequence of an Accidental Injury.
- War or any act of war, whether declared or undeclared, other than acts of terrorism.
- Accidental Injury that occurs while on full-time active duty as a member of the armed forces of any country or subdivision thereof. We will refund, upon written notice of such service, any Premium that has been accepted under this rider for any period not covered as a result of this exclusion.
- Active participation in a riot, insurrection or terrorist activity.
- Committing or attempting to commit a felony.
- Participation in an illegal occupation or activity.
- Intoxication as defined by the jurisdiction where the accident occurred.
- Voluntary intake or use by any means of any drug, other than those prescribed or administered by a Doctor and taken in accordance with the Doctor's instructions or an over-the-counter drug taken in accordance with the manufacturer's instructions.
- Voluntary intake or use by any means of poison, gas or fumes, unless a direct result of an occupational accident.
- Travel in or descent from an aircraft, if the Covered Person acted in a capacity other than as a passenger.
- Travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, used for travel beyond the earth's atmosphere.
- Riding in or driving an air, land or water vehicle in a race, speed or endurance contest.

Benefits under this rider are not payable for loss caused or contributed to by a Covered Person's Accidental Injury that occurs while the Covered Person is incarcerated.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: ODP International, LLC

GROUP POLICY NUMBER: 74634-7GAT2

Applicable only to Associates who have Spouse and/or Children's AD&D insurance without Spouse and Children's life insurance

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

BASIC EMPLOYEE AD&D INSURANCE
Basic Employee AD&D insurance is Noncontributory by Employees.

Eligible Class(es)	Full Amount
All Eligible Associates	Equal to the amount of Basic Employee life insurance

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF BASIC EMPLOYEE AD&D INSURANCE FOR CLASS 1 ASSOCIATES WHO ARE CLASSIFIED AS VICE PRESIDENT AND ABOVE
$500,000

MAXIMUM AMOUNT OF BASIC EMPLOYEE AD&D INSURANCE FOR CLASS 2 ALL OTHER ASSOCIATES
$250,000

The Basic Employee AD&D insurance amount will not exceed the Basic Employee life insurance amount in force.

SUPPLEMENTAL EMPLOYEE AD&D INSURANCE

Supplemental Employee AD&D insurance is Contributory by Employees.

Eligible Class(es)	Full Amount
All Eligible Associates	Choice of 1, 2, 3, 4, 5, 6 or 7 times your Basic Yearly Earnings, with a minimum of $20,000

An insurance amount that does not equal an increment of $10,000 is rounded to the next higher $10,000.

MAXIMUM AMOUNT OF SUPPLEMENTAL EMPLOYEE AD&D INSURANCE FOR ALL ELIGIBLE ASSOCIATES

$2,000,000

EMPLOYEE BENEFIT REDUCTIONS FOR ALL ELIGIBLE ASSOCIATES

Basic Employee AD&D insurance

Your insurance amount will decrease as follows:

- To 65% of the original amount on the Policy anniversary that is on or next follows your 65th birthday.
- To 45% of the original amount on the Policy anniversary that is on or next follows your 70th birthday.
- To 30% of the original amount on the Policy anniversary that is on or next follows your 75th birthday.
- To 20% of the original amount on the Policy anniversary that is on or next follows your 80th birthday.
- To 15% of the original amount on the Policy anniversary that is on or next follows your 85th birthday.

Reduced insurance amounts are not rounded.

SUPPLEMENTAL SPOUSE AD&D INSURANCE

Supplemental Spouse AD&D insurance is Contributory by Employees.

Eligible Class(es)	Full Amount
Spouse only	50% of Employee Supplemental AD&D amount
Spouse when child(ren) are also covered	40% of Employee Supplemental AD&D amount

MAXIMUM AMOUNT OF SUPPLEMENTAL SPOUSE AD&D INSURANCE

$1,000,000

SUPPLEMENTAL CHILDREN'S AD&D INSURANCE

Supplemental Children's AD&D insurance is Contributory by Employees.

Eligible Class(es)	Full Amount
Child(ren) only	15% of Employee Supplemental AD&D amount
Child(ren) when Spouse also covered	10% of Employee Supplemental AD&D amount

MAXIMUM AMOUNT OF SUPPLEMENTAL CHILDREN'S AD&D INSURANCE

$50,000

ACCIDENTAL DEATH BENEFIT

For:	Benefit Amount:
Loss of life	Full Amount of AD&D insurance

ACCIDENTAL DISMEMBERMENT BENEFITS

For:	Benefit Amount:
Loss of an Arm	50% of the Full Amount of AD&D insurance
Loss of a Leg	50% of the Full Amount of AD&D insurance
Loss of a Hand	50% of the Full Amount of AD&D insurance
Loss of a Foot	50% of the Full Amount of AD&D insurance
Loss of a Finger	5% of the Full Amount of AD&D insurance to a maximum of $100 per finger
Loss of a Toe	5% of the Full Amount of AD&D insurance to a maximum of $100 per toe

OTHER ACCIDENTAL LOSS BENEFITS

For:	Benefit Amount:
Loss of Sight in both eyes	100% of the Full Amount of AD&D insurance
Loss of Sight in one eye	50% of the Full Amount of AD&D insurance
Loss of Speech	50% of the Full Amount of AD&D insurance
Loss of Hearing	50% of the Full Amount of AD&D insurance
Paralysis of all four limbs	100% of the Full Amount of AD&D insurance
Paralysis of three limbs	75% of the Full Amount of AD&D insurance
Paralysis of two limbs	75% of the Full Amount of AD&D insurance
Paralysis of one limb	25% of the Full Amount of AD&D insurance
Brain Damage	25% of the Full Amount of AD&D insurance to a maximum of $25,000
Coma	20% of the Full Amount of AD&D insurance to a maximum of $50,000
Burn Disfigurement	25% of the Full Amount of AD&D insurance to a maximum of $25,000
HIV	25% of the Full Amount of AD&D insurance to a maximum of $50,000

Only one Full Amount is payable for any combination of the losses listed above per Covered Person. For example: if the Covered Person has a loss for which the Benefit Amount paid was 50% of the Full Amount of that Covered Person's AD&D insurance, then the Benefit Amount for that Covered Person's next loss will be no more than 50% of the Full Amount.

ADDITIONAL ACCIDENT BENEFITS

Benefit:	Additional Amount:
Common Carrier	Equal to 100% of the full Benefit Amount for the loss to a maximum of $500,000
Safety Belt use	Equal to 25% of the full Benefit Amount for loss of life to a maximum of $25,000
Airbag use	Equal to 10% of the full Benefit Amount for loss of life to a maximum of $5,000
Transportation/Repatriation	Equal to 2% of the full Benefit Amount for loss of life to a maximum of $2,000

Child Care (per child)	Equal to 12% of the full Benefit Amount for loss of life annually up to a total of $10,000 for all children
Child education (per student)	Equal to 20% of the full Benefit Amount for loss of life up to a total of $10,000 for all students
Spouse education	Equal to 3% of the full Benefit Amount for loss of life up to a total of $5,000 per academic year for up to 4 years
Elder care	Equal to 5% of the full Benefit Amount for loss of life to a maximum of $20,000
Occupational assault	Equal to 100% of the full Benefit Amount for the loss to a maximum of $10,000
Felonious assault	Equal to 20% of the full Benefit Amount for the loss to a maximum of $20,000

DEFINITIONS

Accidental Injury means a bodily injury sustained by a Covered Person, which is a direct result of an accident, independent of disease or bodily or mental illness or infirmity or any other cause, and which occurs while the Covered Person's insurance under this rider is in force. Accidental Injury includes bodily injury caused by exposure to the elements when the exposure is a direct result of an accident.

Airbag means a passenger restraint system properly installed in the Automobile in which the Covered Person was riding at the time of the Accidental Injury, which inflates for added protection to the head and chest areas.

Automobile means any self-propelled private passenger vehicle which has four or more tires and which is not being used for commercial purposes.

Basic Yearly Earnings means the yearly salary or wage you receive for work done for the Employer as of the later of the Policy effective date, or the immediately preceding Policy anniversary date, or your hire date. It does not include bonuses, commissions or overtime pay.

Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material duties of everyday life, as determined by a Doctor.

Burn Disfigurement means damage to the skin or other body parts resulting in permanent scarring on at least 5% of the body, resulting from extreme heat, flame, contact with heated objects, or chemicals.

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child for whom you are a legal guardian.

The child must also meet all of the following conditions:

- Be unmarried.
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

For benefits other than death, this definition includes your Children from the date of birth.

Child Care means any facility or private care that:
- is licensed as child care by the state,
- provides non-medical care and supervision for children, and
- is not operated by you or a member of your immediate family.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused, as determined by a Doctor, and which continues for a period of 30 days.

Common Carrier means any commercial transportation that operates on a regularly scheduled basis between predetermined points or cities, and the public conveyance is operated by and licensed for passenger service.

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your eligible Spouse who is enrolled for Contributory Spouse coverage under this rider.
- Your eligible Children who are enrolled for Contributory Children's coverage under this rider.

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Loss of a Finger means the finger is permanently severed from the body through or above the metacarpophalangeal joints (i.e. the third joint from the tip of the finger or the second joint from the tip of the thumb) but below the wrist. See "Loss of a Hand" for loss of the thumb and index finger of the same hand.

Loss of a Foot means the foot is permanently severed from the body at or above the ankle but below the knee.

Loss of a Hand means the hand is permanently severed from the body at or above the wrist, but below the elbow. Loss of a Hand includes loss of the thumb and index finger of the same hand where the thumb and index finger are permanently severed through or above the metacarpophalangeal joints (i.e. the third joint from the tip of the finger or the second joint from the tip of the thumb).

Loss of a Leg means the leg is permanently severed from the body at or above the knee.

Loss of a Toe means the toe is permanently severed from the body at or above the metatarsophalangeal joints but below the ankle.

Loss of an Arm means the arm is permanently severed from the body at or above the elbow.

Loss of Hearing means the entire and irrevocable loss of hearing in both ears, as determined by a Doctor.

Loss of Sight means permanent and uncorrectable loss of sight in an eye, as determined by a Doctor. The visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.

Loss of Speech means the entire and irrevocable loss of speech as determined by a Doctor.

Paralysis means the total impairment of voluntary movement and sensory function of a limb (arm or leg), without severance, and the paralysis is determined by a Doctor to be permanent, complete and irreversible.

Safety Belt means a passenger restraint system properly installed in the Automobile in which the Covered Person was riding at the time of the Accidental Injury, which consists of a belt or strap.

Spouse means your lawful spouse. The person must also meet all of the following:
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee.

The term includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

GENERAL PROVISIONS

EMPLOYEE ELIGIBILITY
If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

SPOUSE ELIGIBILITY
If you are covered for Supplemental Employee AD&D insurance under this rider, then your Spouse is eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Supplemental Employee AD&D insurance coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible under this rider as a Spouse. If you are not covered for Supplemental Employee AD&D insurance under this rider, then your Spouse is not eligible under this rider.

CHILDREN ELIGIBILITY
If you are covered for Supplemental Employee AD&D insurance under this rider, then your Children are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Supplemental Employee AD&D insurance coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible under this rider as a Child. If you are not covered for Supplemental Employee AD&D insurance under this rider, then your Children are not eligible under this rider.

ENROLLMENT

If you are eligible for AD&D coverage, you must enroll for Contributory AD&D coverage before Contributory coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and the Covered Person was covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory AD&D coverage that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EFFECTIVE DATE

For Noncontributory coverage, each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage.

For Contributory coverage, each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date the Covered Person is eligible for coverage, if you enroll for coverage on or before that date.
- The first day of the month that is on or next follows the date you enroll for coverage.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment when the Covered Person's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once AD&D coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The first day of the month that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The first day of the month that is on or next follows the date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.

Any decrease in coverage other than benefit reductions noted on the SCHEDULE OF BENEFITS will take effect at the end of the month but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If your life insurance coverage is being provided under the CHANGE OF INSURANCE CARRIERS provision in the Certificate, then we will also provide continuity of AD&D coverage under the same conditions and for the same duration.

Any benefits payable under this provision will be the lesser of the amount of AD&D coverage under the prior policy had it remained in force, or the amount of eligible AD&D coverage under our Policy. We will reduce our payment by any amount paid under the prior policy.

If the Covered Person was not insured for AD&D under the Employer's prior policy on the date that policy terminated, then the EFFECTIVE DATE provision of this rider will apply.

SPOUSE ACTIVE MILITARY DUTY

If your Spouse is insured under this rider and your Spouse begins full-time active duty in the armed forces of any country or subdivision thereof, then you should notify the Policyholder to cancel Spouse coverage under this rider. Spouse coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse's full-time active military duty ends, then you may re-enroll for Contributory Spouse coverage under this rider within 2 months of the date your Spouse is again eligible for coverage. Contributory Spouse coverage under this rider will become effective on the later of:

- The date you re-enroll for Contributory Spouse coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment when your Contributory Spouse coverage would otherwise become effective. **Exception:** Contributory coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

SPOUSE CHANGE OF LEGAL RESIDENCE

If your Spouse is insured under this rider and your Spouse changes their legal residence to outside the United States or its territories or possessions, then you should notify the Policyholder to cancel Spouse coverage under this rider. Spouse coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse resumes legal residence in the United States or its territories or possessions, then you may re-enroll for Contributory Spouse coverage under this rider within 2 months of the date your Spouse is again eligible for coverage. Contributory Spouse coverage under this rider will become effective on the later of:

- The date you re-enroll for Contributory Spouse coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you retire from Active Employment with the Employer.
- The date you voluntarily cancel this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The end of the period for which Premiums for this rider are paid if the next Premium is not paid by its due date, subject to the Policy's grace period.
- The date a claim is approved under the Waiver of Premium Rider.

Coverage for your Spouse under this rider ends on the earliest of the following:

- The date this rider terminates.
- The date your Supplemental Employee AD&D insurance terminates.
- The date you voluntarily cancel Spouse coverage under this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The last day of the month that is on or next follows the date your Spouse is no longer an eligible Spouse as defined by this rider.

Coverage for each Child under this rider ends on the earliest of the following:

- The date this rider terminates.
- The date your Supplemental Employee AD&D insurance terminates.
- The date you voluntarily cancel Children's coverage under this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The last day of the month that is on or next follows the date the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.

If coverage for your Children ends because you no longer have an eligible Child as defined by this rider, then you should notify the Policyholder to cancel Children's coverage under this rider.

Termination will not prejudice the payment of benefits for a covered loss caused by an Accidental Injury that occurs while the Covered Person is insured under this rider.

CONVERSION
When coverage under this rider terminates, conversion of AD&D coverage to an individual policy is not available.

INCONTESTABILITY
Any statement made by you or your Spouse or Child is considered a representation and not a warranty. We will not use such statement to contest insurance under this rider after it has been in force for two years during the Covered Person's lifetime. We will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during the Covered Person's lifetime.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

BENEFICIARY
Benefits for your death are payable to the Beneficiary. See the Certificate for more information about the Beneficiary.

You are the Beneficiary for proceeds that become payable for all other losses under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. You, or the current owner if ownership was assigned, are automatically the Beneficiary for these proceeds and this designation may not be changed.

AD&D BENEFITS

We pay an AD&D benefit to the Beneficiary if we receive Written proof that a Covered Person suffered a covered loss (as described below) as the result of an Accidental Injury. The Covered Person must be insured under this rider on the date of the Accidental Injury, and the cause of the loss must not be excluded. The AD&D benefit is the amount for the eligible class and for the loss as shown on the SCHEDULE OF BENEFITS in effect on the date of the Accidental Injury.

Accidental Death
A benefit is payable if an Accidental Injury causes a Covered Person's death within 365 days of the Accidental Injury.

We will presume that the Covered Person died as a result of Accidental Injury if all of the following are true:
- The conveyance in which the Covered Person was traveling (including but not limited to an automobile, airplane, ship or train) disappears, sinks or is wrecked.
- The body of the Covered Person is not found.
- A reasonable period of time, but not more than 365 days has elapsed from the later of the date the conveyance was scheduled to arrive at its destination or the date the Covered Person was reported missing to the authorities.

If we pay an Accidental Death benefit due to the Covered Person's disappearance and it is later found that the Covered Person is alive, the benefits paid must be refunded to us.

Accidental Dismemberment
A benefit is payable if an Accidental Injury causes a Covered Person's loss of a covered finger, toe, limb or appendage within 365 days of the Accidental Injury. The types of and benefit amounts for covered Accidental Dismemberment losses are shown on the SCHEDULE OF BENEFITS.

If Accidental Injury causes more than one loss to the same covered digit, limb or appendage, only the largest benefit for the loss will be payable.

Other Accidental Loss
A benefit is payable if an Accidental Injury causes a Covered Person's loss as described below. The benefit amounts for these covered losses are shown on the SCHEDULE OF BENEFITS.

Loss of Sight: The Covered Person has a Loss of Sight in one or both eyes, and the Loss of Sight is continuous for 180 days following the date the Loss of Sight began. Loss of Sight must be diagnosed within 180 days of the Accidental Injury.

Loss of Speech: The Covered Person has a Loss of Speech that is continuous for 180 days following the date the Loss of Speech began. Loss of Speech must be diagnosed within 180 days of the Accidental Injury.

Loss of Hearing: The Covered Person has a Loss of Hearing in both ears, and the Loss of Hearing is continuous for 180 days following the date the Loss of Hearing began. Loss of Hearing must be diagnosed within 180 days of the Accidental Injury.

Paralysis: The Covered Person has Paralysis of one or more limbs. Only one Paralysis benefit is payable per Accidental Injury. Paralysis must be diagnosed within 180 days of the Accidental Injury.

Brain Damage: The Covered Person has Brain Damage that is continuous for 30 days following the date the Brain Damage began. Brain Damage must be diagnosed within 180 days of the Accidental Injury. If both a Brain Damage benefit and a Coma benefit would be otherwise payable due to the same Accidental Injury, then only the larger of the two benefits will be payable.

Coma: The Covered Person is in a Coma that is continuous for 30 days following the date the Coma began. A Coma must be diagnosed within 180 days of the Accidental Injury. If both a Coma benefit and a Brain Damage benefit would be otherwise payable due to the same Accidental Injury, then only the larger of the two benefits will be payable.

Burn Disfigurement: The Covered Person has Burn Disfigurement.

HIV: You contract the Human Immunodeficiency Virus (HIV) as a result of an Accidental Injury sustained while you were performing assigned duties of your employment with the Employer. You must submit a workers' compensation injury report and an initial negative blood test for HIV to the Employer within 72 hours of the Accidental Injury, and you must subsequently test positive for HIV within 6 months of the Accidental Injury. All tests to determine the presence of HIV must be conducted by a Doctor. No HIV benefit is payable for your insured Spouse's or Child's loss.

Additional Accident Benefits

When a benefit is payable under this rider for Accidental Death, Accidental Dismemberment or Other Accidental Loss, an Additional Accident Benefit may be payable under the terms described below. The additional benefit amounts are shown on the SCHEDULE OF BENEFITS.

Common Carrier: The Accidental Injury occurs while the Covered Person is traveling as a passenger in or on a public conveyance classified as a Common Carrier, including entering into or departing from the Common Carrier. A passenger does not include a person who is performing duties for the Common Carrier as part of their employment.

Safety Belt use: The Accidental Injury causing death occurs while the Covered Person is riding in an Automobile equipped with Safety Belts, and the Covered Person was wearing a properly fastened Safety Belt at the time of the Accidental Injury.

If the accident report or other accident records can't verify the Safety Belt use, and payment of this benefit would not otherwise be excluded, then a flat benefit amount of $1,000 is payable.

This benefit is not payable if the death was caused or contributed to by any use of intoxicating liquors, marijuana, narcotic drugs, depressants or similar substances, whether or not prescribed by a Doctor, by the Covered Person or by the driver of the Automobile in which the Covered Person was riding.

Airbag use: The Accidental Injury causing death occurs while the Covered Person is riding in an Automobile equipped with an Airbag for the Covered Person's seat in which the Airbag for the Covered Person's seat operated properly upon impact at the time of the Accidental Injury. The Covered Person must also have been wearing a properly fastened Safety Belt at the time of the Accidental Injury.

If the accident report or other accident records can't verify the Airbag use, and payment of this benefit would not otherwise be excluded, then a flat benefit amount of $1,000 is payable.

This benefit is not payable if the death was caused or contributed to by any use of intoxicating liquors, marijuana, narcotic drugs, depressants or similar substances, whether or not prescribed by a Doctor, by the Covered Person or by the driver of the Automobile in which the Covered Person was riding.

Transportation/Repatriation: The Covered Person's accidental death occurs at least 100 miles from the Covered Person's primary residence.

Child Care: Your dependent Child under age 13 is enrolled in Child Care within 31 days of the date of a Covered Person's death for which a benefit is payable under this rider. No Child Care benefit is payable for your insured Spouse's or Child's death. You or the Beneficiary must provide proof annually that your Child remains eligible. Benefits will stop when your Child is no longer eligible.

If you do not have an eligible dependent Child, a flat benefit amount of $1,000 is payable.

Child education: Your dependent Child is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of a Covered Person's death for which a benefit is payable under this rider. No child education benefit is payable for your insured Spouse's or Child's death. To be considered full-time, your Child's full-time school attendance must be 6 months or more in each annual period following enrollment. Benefits are payable at the end of each annual period following enrollment. You or the Beneficiary must provide proof annually that your Child remains eligible. Benefits will stop when your Child is no longer eligible.

If you do not have an eligible dependent Child, a flat benefit amount of $1,000 is payable.

Spouse education: Your Spouse is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of your death for which a benefit is payable under this rider. No spouse education benefit is payable for your insured Spouse's or Child's death. To be considered full-time, your Spouse's full-time school attendance must be 6 months or more in each annual period following enrollment. Benefits are payable at the end of each annual period following enrollment. The Beneficiary must provide proof annually that your Spouse remains eligible. Benefits will stop when your Spouse is no longer eligible.

If you do not have an eligible Spouse, a flat benefit amount of $1,000 is payable.

Elder care: A relative age 60 or older is dependent on the Covered Person for support and maintenance at the time of the Covered Person's death, and either resided with the Covered Person or incurred expenses for a nursing home or home health care which were partially or fully paid by the Covered Person. Only one elder care benefit is payable under this rider. No elder care benefit is payable for your insured Spouse's or Child's death. You or the Beneficiary must provide proof of an eligible relative in order to receive this benefit.

A relative for this benefit means your Spouse, your sibling, your parent, your grandparent, or the sibling, parent, or grandparent of your Spouse. If the Covered Person does not have an eligible relative, a flat benefit amount of $1,000 is payable.

Occupational assault: Your loss for which a benefit is payable under this rider is the result of an intentional and unlawful act of physical violence directed at you by another person while you were performing assigned duties of your employment with the Employer. A report of criminal activity must be filed by you or on your behalf with the appropriate law enforcement authority within 48 hours of the assault. No occupational assault benefit is payable for your insured Spouse's or Child's loss. If an occupational assault benefit and a felonious assault benefit would be otherwise payable for the same loss, then only the larger of the benefits will be payable.

Felonious assault: Your loss for which a benefit is payable under this rider is the result of a violent or criminal act directed at you by another person during the course of or attempt at robbery or hold-up, or a kidnapping involving Policyholder funds. No felonious assault benefit is payable for your insured Spouse's or Child's loss. If a felonious assault benefit and an occupational assault benefit would be otherwise payable for the same loss, then only the larger of the benefits will be payable.

NOTICE OF CLAIM AND PROOF OF LOSS

You or the Beneficiary must send us Written notice of claim within 90 days after the date of loss. Failure to give notice within 90 days will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of loss. Proof of loss for a death claim consists of a certified copy of the Covered Person's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds. Proof of loss for any other claim consists of information from the Covered Person's Doctor, at your expense, regarding the Covered Person's loss that is covered under this rider. We may require additional information from the Employer in order to verify eligibility. Proof of loss, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). A claim form is available from the Employer or us.

We will review proof of loss we receive in order to determine our liability and the correct payee(s).

PHYSICAL EXAMINATION

We may require the Covered Person to be examined, at our expense, by one or more Doctors or other medical practitioners of our choice. We can require an examination as often as it is reasonable to do so for the duration of a claim.

PAYMENT OF PROCEEDS

If the Beneficiary is not living on the date payment is made, benefits are payable to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on death benefit proceeds, accruing from the date of the Covered Person's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) - APPLICABLE TO ALL OTHER CLAIMS
Refer to the Certificate provision.

EXCLUSIONS

Benefits under this rider are not payable for any loss caused or contributed to by any of the following:

- Suicide or attempted suicide, or intentionally self-inflicted injury, regardless of mental capacity.
- Disease or infirmity of mind or body, or medical and surgical treatment for such disease or infirmity.
- An infection, other than an infection that is a direct result or consequence of an Accidental Injury.
- War or any act of war, whether declared or undeclared, other than acts of terrorism.
- Accidental Injury that occurs while on full-time active duty as a member of the armed forces of any country or subdivision thereof. We will refund, upon written notice of such service, any Premium that has been accepted under this rider for any period not covered as a result of this exclusion.
- Active participation in a riot, insurrection or terrorist activity.
- Committing or attempting to commit a felony.
- Participation in an illegal occupation or activity.
- Intoxication as defined by the jurisdiction where the accident occurred.
- Voluntary intake or use by any means of any drug, other than those prescribed or administered by a Doctor and taken in accordance with the Doctor's instructions or an over-the-counter drug taken in accordance with the manufacturer's instructions.
- Voluntary intake or use by any means of poison, gas or fumes, unless a direct result of an occupational accident.
- Travel in or descent from an aircraft, if the Covered Person acted in a capacity other than as a passenger.
- Travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, used for travel beyond the earth's atmosphere.
- Riding in or driving an air, land or water vehicle in a race, speed or endurance contest.

Benefits under this rider are not payable for loss caused or contributed to by a Covered Person's Accidental Injury that occurs while the Covered Person is incarcerated.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.
The mailing address is:

PO Box 20
Minneapolis, Minnesota 55440-0122
Telephone: (800) 537-5024

You have the right to file a complaint with the Arkansas Insurance Department (AID). A complaint can be filed online at the AID website https://insurance.arkansas.gov.

You may also contact AID to request a complaint form be mailed to you by calling AID at (800) 852-5494 or (501) 371-2640.

You may also request in writing for a complaint form to be mailed to you. Mail your request to:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS
KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55401

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE HAWAII LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of Hawaii who purchase life insurance, annuities, or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumer's care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Hawaii Life and Disability Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Hawaii. You should not rely on coverage by the Hawaii Life and Disability Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The Hawaii Life and Disability Insurance Guaranty Association
1132 Bishop Street, Suite 1590
Honolulu, Hawaii 96813

Department of Commerce and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if –

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or an insurance exchange are examples of nonmember insurers.

The Guaranty Association also does **not** provide coverage for –

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits and with regard to one owner of multiple non-group policies of life insurance.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant’s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association’s limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

ReliaStar Life Insurance Company
Minneapolis, Minnesota

MISSOURI CERTIFICATE ENDORSEMENT
for Group Term Life Insurance

Your Certificate has been changed to include this endorsement. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy, Certificate, riders and endorsements issued.

EXCLUSIONS

If your Certificate contains an exclusion for suicide, this exclusion will be for no more than one year from the date insurance starts. This also applies to any Spouse Life Insurance Rider and Children's Life Insurance Rider.

ACCIDENTAL DEATH RIDER OR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes an Accidental Death Rider or AD&D Rider, then this statement is added to the EXCLUSIONS section:

> These exclusions do not include the following: unintentional or non-voluntary inhalation of gas or taking of poisons; pyogenic infections which result from an Accidental Injury; or bacterial infections which result from the accidental ingestion of contaminated substances.

All other Accidental Death or AD&D exclusions remain unchanged.

Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
Minneapolis, Minnesota

MONTANA CERTIFICATE ENDORSEMENT
for Group Term Life Insurance

Your Certificate has been changed to include this endorsement. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy, Certificate, riders and endorsements issued.

GENERAL PROVISIONS

The following paragraph is added to the INCONTESTABLITY provision in your Certificate:

> The Policy also has an INCONTESTABILITY provision. Any statement made by the Policyholder is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written application which has been made a part of the Policy. Except for fraud, we will not use such statement to contest life insurance after it has been in force for two years from its effective date. Fraud in the procurement of the Policy is only contestable after the Policy has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction. The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

The following provisions are added to your Certificate:

GRACE PERIOD

The Policyholder has a grace period of 31 days for the payment of any Premium due except the first. During the grace period the Policy will remain in force. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination, as described under the POLICY TERMINATION provision.

If full Premium payment is not received by us by the due date, we will give Written notification to the Policyholder that if the Premium is not paid by the end of the grace period then the Policy will end on the last day of the grace period. If we fail to give such Written notice, the insurance provided under the Policy will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to the Policyholder, and such notice will specify the date the Policy will terminate if the Premium remains unpaid.

If the Policyholder replaces this Policy with another group policy but does not give us Written notice of intent to terminate this Policy, then this grace period provision will still apply.

The Policyholder is required to pay a pro rata Premium for any period the Policy was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which insurance under this Policy was in effect and Premium was not paid.

CONFORMITY WITH MONTANA STATUTES

The provisions of the Certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which you reside on or after the effective date of your coverage under the Policy.

LIFE INSURANCE BENEFITS

The following paragraph is added to the PAYMENT OF INTEREST provision in your Certificate:

If payment of proceeds is made after the first 30 days following the date we receive proof of death, the interest rate from the 30th day until the date of payment will be the greater of these:

- The monthly average discount rate on 90-day AA asset-backed commercial paper in effect at the federal reserve bank in the ninth federal reserve district on the date proof of death is received.
- The rate stated in your Certificate.

Melissa A. O'Donnell
Secretary

NOTICE OF PROTECTION PROVIDED BY
NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies. For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of type of coverage, is $300,000; however, may be up to $500,000 with regard to health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTC).

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life policy or annuity contract to which it relates.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org, or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota, 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit, or induce you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

ReliaStar Life Insurance Company
Minneapolis, Minnesota

OREGON ACCELERATED BENEFIT DISCLOSURE
for Group Term Life Insurance

Please keep this disclosure with your Certificate.

Your Certificate includes an Accelerated Death Benefit Rider that provides a benefit if a covered person is diagnosed with a Qualifying Event. This rider provides payment of a percentage of the death benefit otherwise payable, as noted in the rider, while the covered person is living. The accelerated death benefit payment reduces the amount of life insurance payable at death.

"Qualifying Event" means either of the following:

- Terminal Illness.
- A medical condition that is reasonably expected to require continuous confinement in an institution and the covered person is expected to remain there for the rest of his or her life.

"Terminal Illness" means a medical condition that is expected to result in the covered person's death within 12 months and from which there is no reasonable chance of recovery.

The cost of the accelerated death benefit is incorporated into the cost of life insurance and is not a separately identifiable premium. When an eligible claim is paid, an administrative expense charge may be subtracted from the payment.

Following payment of accelerated death benefits, future life insurance premiums for the covered person will be waived.

Please refer to the rider for the provisions that relate to your Certificate.

The receipt of accelerated death benefits may be a taxable event, and you should seek additional information about the tax status of the payment from a personal tax advisor.

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities

- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

ReliaStar Life Insurance Company
Minneapolis, Minnesota

SOUTH DAKOTA CERTIFICATE ENDORSEMENT
for Group Term Life Insurance

Your Certificate has been changed to include this endorsement. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy, Certificate, riders and endorsements issued.

ACCIDENTAL DEATH RIDER OR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes an Accidental Death Rider or AD&D Rider, then any reference to mental illness or infirmity in the definition of "Accidental Injury" does not apply.

The EXCLUSIONS are also revised as follows:

The exclusion for disease or infirmity is changed to read:

- Disease or infirmity of the body, or medical and surgical treatment for such disease or infirmity.

Any exclusion for felonies is changed to read:

- Committing a felony.

Any exclusion for participation in an illegal occupation or activity does not apply.

Any exclusion for intoxication does not apply.

Any exclusion for use of drugs does not apply.

Any exclusion for voluntary intake of poison, gas or fumes does not apply.

If your Certificate includes an Accidental Death Rider, any exclusion for suicide on that rider is changed to read:

- Death as a result of suicide, while sane, within two years of the date the Covered Person's insurance under this rider starts.

All other Accidental Death or AD&D exclusions remain unchanged.

Secretary
ReliaStar Life Insurance Company

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy owners, contract owners, and certificate owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and required continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy or contract.

Coverage is NOT provided for your policy or contract for any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy or contract.

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

(Please turn to back of page)

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy owner, contract owner or certificate owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D Coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more that $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health benefit plans, not more than $500,000, but not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance, and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to health benefit plans, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statues governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

RELIASTAR LIFE INSURANCE COMPANY

Home Office: Minneapolis, Minnesota

Texas Accelerated Death Benefit Disclosure Notice:

The accelerated death benefit under this Group Policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the accelerated death benefit qualifies for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive accelerated benefits excludable from income under federal law.

Receipt of accelerated death benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

R-08121a

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tamblen debe presenter una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

ReliaStar Life Insurance Company

Para obtener informacion o para presenter una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

NOTICE OF PROTECTION PROVIDED BY
VERMONT LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Vermont Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Vermont law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Vermont law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).) The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender and withdrawal values
- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability [income] insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in 8 V.S.A. Section 4175 (11) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Vermont law.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, [as well as protections relating to group contracts or retirement plans,] please visit the Association's website at www.vtlifega.org, or contact:

Vermont Life and Health Insurance Guaranty Association
One National Life Drive, Suite M585
Montpelier, Vermont 05604
802 -552-3698

Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620
802-828-3301

Insurance companies and agents are not allowed by Vermont law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Vermont law, then Vermont law will control.

ReliaStar Life Insurance Company
Minneapolis, Minnesota

VIRGINIA BENEFICIARY DESIGNATION NOTICE
for Group Term Life Insurance

Please keep this notice with your Certificate.

BENEFICIARY DESIGNATION MAY NOT APPLY IN THE EVENT OF ANNULMENT OR DIVORCE

Under Virginia law (Virginia Code Section 20-111.1), a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary becomes void upon the entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of the following courses of action is taken prior to the entry of a decree of annulment or divorce:

- Change the beneficiary designation to make it irrevocable.
- Change the ownership of the policy or contract.
- Execute a separate written agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of entry of the decree of annulment or divorce.
- Make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to Section 20.111.1.

ReliaStar Life Insurance Company
Minneapolis, Minnesota

WASHINGTON CERTIFICATE ENDORSEMENT
for Group Term Life Insurance

Your Certificate has been changed to include this endorsement. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy, Certificate, riders and endorsements issued.

GENERAL PROVISIONS
Your Certificate is revised to add the following provision:

LABOR DISPUTE
If the Policyholder pays all or part of the Premiums for your coverage, and you stop Active Employment due to a strike, lockout or other labor dispute, then you may continue your coverage for up to 6 months by paying the Premiums directly to the Policyholder as they become due.

EXCLUSIONS
If your Certificate contains an exclusion for suicide, this exclusion does not apply to life insurance. This change also applies to any Spouse Life Insurance Rider and Children's Life Insurance Rider.

ACCIDENTAL DEATH RIDER OR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER
If your Certificate includes an Accidental Death Rider or AD&D Rider, then various provisions are revised as follows:

The time period in the Accidental Death provision between Accidental Injury and death is changed to one year.

The time period in the Accidental Dismemberment provision between Accidental Injury and loss is changed to one year.

If the rider includes an HIV or a Hepatitis B or C benefit, the time period in that provision between Accidental Injury and the second test is changed to one year.

If the rider includes a Child Care benefit, the time period in that provision between death and the date of enrollment in Child Care is changed to one year.

If the rider includes a Child education benefit, and if the time period in that provision between death and the date of school enrollment is less than one year, then that time period is changed to one year.

If the rider includes a Spouse education benefit, and if the time period in that provision between death and the date of school enrollment is less than 1 year, then that time period changed to one year.

If the rider includes a Spouse training benefit, and if the time period in that provision between death and the date of enrollment in training is less than 1 year, then that time period is changed to one year.

If the rider includes a rehabilitation benefit, and if the time period in that provision between loss and the Doctor's prescription for services is less than 1 year, then that time period is changed to one year.

If the rider includes a home or vehicle modification benefit, and if the time period in that provision between loss and the Doctor's prescription for modifications is less than 1 year, then that time period is changed to one year.

If the rider includes a therapeutic counseling benefit, and if the time period in that provision between loss and the prescription and receipt of counseling is less than 1 year, then that time period is changed to one year.

If the rider includes a Total and Permanent Disability benefit, the time period in that provision between loss and Total and Permanent Disability is changed to one year.

All other Accidental Death or AD&D provisions remain unchanged.

ACCELERATED DEATH BENEFIT RIDER

If your Certificate includes the Accelerated Death Benefit Rider, then this paragraph is added:

The accelerated death benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated death benefit from being marketed or sold as long-term care. If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

If the definition of Terminal Illness in the Accelerated Death Benefit Rider has a time period of less than 24 months, then that time period is changed to 24 months.

All other accelerated death benefit provisions remain unchanged.

Secretary
ReliaStar Life Insurance Company

Wisconsin Complaint Notice

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.

ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-800-955-7736

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.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

Plan Name, Number and Name and Address of :
ODP International, LLC
74634-7GAT2
ODP International, LLC
6600 North Military Trail
Boca Raton, Florida, 33496

Name, Address, and Telephone Number of the Plan Administrator:
ODP International, LLC
6600 North Military Trail
Boca Raton, Florida, 33496

Identification Numbers
IRS Employer Identification Number: 87-2687219
Plan Number: 501

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Employer and Employee paid

Plan Year: January - December

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Policyholder makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Policyholder reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR LIFE INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR WAIVER OF PREMIUM RIDER

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) Prior to rendering an adverse decision on appeal, ReliaStar Life will provide notice to the claimant of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. ReliaStar Life Insurance Company of New York will also notify the claimant if it has new or additional rationale for an adverse appeal determination. ReliaStar Life Insurance Company of New York will then provide the claimant with a reasonable opportunity to review and respond to this new information before making its decision. The time period ReliaStar Life Insurance Company of New York has to make its determination will be tolled while it is waiting for the claimant's response.
8) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. If ReliaStar Life Insurance Company of New York sends an adverse benefit determination following its review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
   a. The specific reason(s) for the adverse benefit determination.
   b. Reference to the specific provision on which the determination 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 claim.
   d. A statement of the claimant's right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
   e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
   f. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

9) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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