

## Certificate of Insurance

**Securian Life Insurance Company** • A Stock Company  
400 Robert Street North • St. Paul, Minnesota 55101-2098

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We certify that, subject to the terms of the Policy, the Member named in the Schedule (referred to as “you”, “your”, and “yours”) is insured for the benefits described in this Certificate. Your eligible Dependent, if any, for whom premiums have been paid is also insured for the benefits described in this Certificate. You and your Dependent are referred to as the Covered Person.

### EFFECTIVE DATE OF INSURANCE

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown on the Schedule.

In this Certificate, Securian Life Insurance Company will be called “we”, “our”, or “us”. This Certificate summarizes certain provisions of the Policy. All coverage and provisions are subject to those in the Policy issued to the Policyholder.

### THIRTY DAY RIGHT TO EXAMINE CERTIFICATE

If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

This Certificate is executed on the Effective Date, at St. Paul, Minnesota.

**THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. THIS CERTIFICATE DOES NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH INSURANCE COVERAGE, WHICH BECAME EFFECTIVE JANUARY 1, 2014.**

THIS IS A LIMITED BENEFIT CERTIFICATE: This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare available from us.

### NON-CONTRIBUTORY CERTIFICATE OF INSURANCE ACCIDENT ONLY INSURANCE NON-PARTICIPATING

  
Secretary

  
President

## INDEX

<u>Provision</u>	<u>Page Number</u>
Accidental Death Benefit	4
Changes in Coverage	4
Claim Provisions	9
Definitions	3
Eligibility and Effective Date	4
Exclusions	6
General Provisions	8
Individual Termination of Insurance	7
Premiums	7
Schedule of Benefits	2

**SCHEDULE OF BENEFITS**

Policyholder: Legionnaire Insurance Trust  
Policy Number: 9003  
Original Certificate Effective Date: Date your coverage is activated  
  
Insured Person(s): Effective Date:  
  
Member: Legionnaire Date your coverage is activated

**NON-CONTRIBUTORY COVERAGE**

**ACCIDENTAL DEATH BENEFIT**

Amount of Insurance: \$1,000

**ACCIDENTAL DISMEMBERMENT BENEFIT**

Principal Sum: \$1,000

**ASSOCIATION MEMBER TRAVELING BENEFIT**

Principal Sum: \$5,000

**ADDITIONAL BENEFITS**

**AMOUNTS & LIMITS**

Accidental Ingestion of a Controlled Drug Benefit

\$500 per Calendar Year

Emergency Room and Ambulance

Emergency Room

\$10 per visit  
Maximum number of visits per year  
1 per covered person.

Ambulance

Benefit amount equal to incurred expenses for Ambulance transportation, which shall not exceed the maximum allowable rate established by the Connecticut Department of Public Health in accordance with Section 19a-177

## DEFINITIONS

When used in this Certificate the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**AIRCRAFT** means a vehicle which: 1) has a valid certificate of airworthiness; and 2) is being flown by a pilot with a valid license to operate the vehicle.

**BENEFICIARY** means the person or entity named by the insured Member, on forms and in a manner approved by us, to receive benefits.

**COVERED PERSON** means the insured Member.

**INJURY** means bodily injury caused by an accident. The accident must be unintended, unexpected and unforeseen and occur while the Covered Person's insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes.

**LOSS** means the death of the Covered Person or any physical impairment or other benefit covered under the terms of the Policy and any attached Riders.

**LOSS OF A HAND OR FOOT** means complete Severance through or above the wrist or ankle joint.

**LOSS OF SIGHT** means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means. Loss of Sight must be certified by a licensed physician who specializes in ophthalmology and is certified by the American Board of Ophthalmology.

**LOSS OF THUMB AND INDEX FINGER** means complete Severance through or above the metatarsophalangeal joint.

**MEMBER** means a member of a the Policyholder who has been accepted by us and has paid any required premium. The terms "you", "your" and "yours" mean the Member.

**PHYSICIAN** means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given.

Physician includes a chiropractor if the chiropractor is practicing within the scope of his license for the service or treatment given.

A Covered Person and his immediate family will not be considered a Physician.

**POLICY** means the group policy issued to the Policyholder providing the benefits described.

**POLICYHOLDER** means the legal entity in whose name the Policy is issued, as shown on the Schedule.

**POLICY MONTH** means the period of time starting on the first day of the month; it ends on the last day of the same month.

**SCHEDULE** means the Schedule of Benefits.

**SEVERANCE** means the complete and permanent separation and dismemberment of the part from the body.

## **ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE**

### **ELIGIBILITY**

Active Members in good standing age 18 and over with a domestic U.S. address including military personnel stationed overseas will be eligible for insurance as Covered Persons.

### **EFFECTIVE DATE OF INSURANCE**

**EFFECTIVE DATE** The Effective Date is shown on the Schedule.

### **CHANGES IN COVERAGE**

If, after the Effective Date of Insurance, you request a change in benefits for a Covered Person, the Effective Date of Insurance for the new coverage will be the beginning of the Policy Month following our acceptance of the application or change request, subject to the payment of any additional required premium.

### **ACCIDENTAL DEATH BENEFIT**

When we receive due proof that a Covered Person dies, we will pay the benefit shown on the Schedule to his named Beneficiary; provided:

- (1) death occurs as a direct result of an Injury; and
- (2) death occurs within 365 days of the accident causing the Injury.

## ACCIDENTAL DISMEMBERMENT BENEFIT

When we receive due proof of your loss as described in the table below we will pay the applicable benefit if your loss occurs:

- (1) as a direct result of an Injury; and
- (2) 365 days of the accident causing the Injury.

### TABLE OF LOSSES AND BENEFITS

<b><u>Loss:</u></b>	<b><u>Benefit:</u></b> (Percentage of Principal Sum Shown on the Schedule)
Two or more Hands or Feet	100%
Sight of Both Eyes	100%
One Hand or Foot	50%
Sight of One Eye	50%
Thumb and Index Finger of Same Hand	50%

## ASSOCIATION MEMBER TRAVELING BENEFIT

### For Accidental Loss of Life

Upon receipt of due proof of your death, we will pay the Loss of Life benefit shown in the table below if your death occurs:

- (1) as a direct result of an Injury; and
- (2) within 365 days of the accident causing the Injury; and
- (3) while traveling on American Legion business, attending or participating in events sponsored by the American Legion or an American Legion affiliate; or while traveling to or from such event.

### For Accidental Loss of Limb or Sight

Upon receipt of due proof of your accidental loss of limb or sight as described in the table below we will pay the applicable benefit if your loss occurs:

- (1) as a direct result of an Injury; and
- (2) within 365 days of the accident causing the Injury; and
- (3) while traveling on American Legion business, attending or participating in events sponsored by the American Legion or an American Legion affiliate; or while traveling to or from such event.

If you die after we have paid any Accidental Loss of Limb or Sight Benefit, we will then pay the Accidental Loss of Life benefit less any Accidental Loss of Limb or Sight benefit already paid.

## TABLE OF LOSSES AND BENEFITS

<b><u>Loss:</u></b>	<b><u>Benefit:</u></b> (Percentage of Principal Sum Shown on the Schedule)
Life	100%
Two or more Hands or Feet	100%
Sight of Both Eyes	100%
One Hand or Foot	50%
Sight of One Eye	50%

## EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Injury or Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following:

- (1) intentionally self-inflicted injury, suicide or any attempt thereof while sane or insane;
- (2) declared or undeclared war or act of war;
- (3) military or combat activities while serving in the armed forces, National Guard, or organized reserve corps in any state, country, or international authority (upon request and proof of military or combat activity while serving, we will return the pro rata portion of the premium paid for any such period of service);
- (4) bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of accidental food poisoning.
- (5) flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
  - a. except as a fare paying passenger on a regularly scheduled commercial airline;
  - b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
  - c. being used for:
    - i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, pipeline or power line inspection, aerial photography or exploration; or
    - ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
  - d. designed for flight above or beyond the earth's atmosphere;
  - e. an ultra-light or glider;
  - f. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;

- (6) the Covered Person's intoxication defined as meeting or exceeding the legal limit of intoxication according to the laws of the jurisdiction in which the accident occurred;
- (7) voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Covered Person's Physician.

### **INDIVIDUAL TERMINATION OF INSURANCE**

A Covered Person's insurance automatically ends on the first of the following dates:

- (1) The date the Policy is terminated;
- (2) The date the Grace Period ends if all premiums due have not been paid;
- (3) The premium due date after you are no longer a member of the Policyholder.

### **PREMIUMS**

We provide insurance coverage in return for premium payment. Premiums are paid to us on or before the due date.

**PREMIUM CHANGES** We have the right to change the premium rates on any premium due date. We will provide written notice at least 31 days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed upon request. Upon our approval, the change will be made.

**GRACE PERIOD** This Certificate has a 31 day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the grace period.

**REINSTATEMENT OF INSURANCE** If we terminate insurance for nonpayment of premium, you may reinstate coverage within 90 days following the last unpaid premium due date. You must pay all overdue premium. The reinstated coverage will not cover a loss which occurred during the lapse period.

**UNPAID PREMIUM** When a claim is paid for a loss incurred during the Grace Period, any premium due and unpaid may be deducted from the claim payment.



## GENERAL PROVISIONS

**BENEFICIARY CHANGES** You may name any person to be your Beneficiary at the time of enrollment. You may change your Beneficiary at any time. When we receive and record the change request, it will take effect as of the date you signed it. If you die prior to the date we receive and record the change, any payment we make to the new Beneficiary will be valid. The prior Beneficiary's interest ends the date the new designation takes effect.

If more than one Beneficiary is named without stating their respective interests, they will share equally. If a Beneficiary dies before you, that interest ends. The Beneficiaries that survive will share equally unless you make a written request to the contrary.

**CONFORMITY TO LAW** Any provision of the Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

**INCONTESTABILITY** After coverage under the Policy has been in force for two years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after his insurance has been in force two years during his lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by him.

**MISSTATEMENT OF AGE** If the age of a Covered Person has been misstated in the enrollment form for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon his correct age, otherwise, there will be an equitable adjustment of premiums.

**NONPARTICIPATING** The Policy is a nonparticipating Policy; it does not share in our surplus.

**OPTIONAL SETTLEMENT METHODS** You, or the Beneficiary after the Covered Person's death, may elect to have loss of life benefits paid in installments. Such election must be sent to us in writing. The amounts and terms of the installments will be those which we offer at the time of election.

**POLICY CHANGES** The Policy may be changed at any time by written agreement between us. No change or waiver of any of the provisions of the Policy will be valid unless made in writing by us and signed by our president, vice president, secretary or assistant secretary. No agent or other person has the authority to change or waive any provisions of the Policy.

**WORKER'S COMPENSATION** The Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation Insurance.

## CLAIM PROVISIONS

**NOTICE OF CLAIM** We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice must contain the Covered Person's name and enough information to identify him. Notice may be mailed to our Home Office or to our agent.

**CLAIM FORMS** When we receive notice of claim, the Covered Person will be sent forms to file proof of loss. If the forms are not sent within 15 days after we receive notice, then the Covered Person will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

**PROOF OF LOSS** Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

**PAYMENT OF CLAIMS** Claims for benefits provided by the Policy will be paid as soon as written proof is received.

Your loss of life benefits will be paid in accordance with the beneficiary designation in effect at the time of payment. If there is no such designation or no surviving beneficiary, the loss of life benefits will be paid in one lump sum to the first surviving class of the following classes of beneficiaries:

- a) lawful spouse;
- b) child(ren), in equal shares;
- c) parents, in equal shares;
- d) siblings, in equal shares.

If there is no surviving member of any of the above classes, the benefits will be paid to your estate.

All benefits, other than loss of life, will be paid to you, if living. Any accrued benefits unpaid at your death will be paid in one lump sum to the first surviving class of the following classes of beneficiaries:

- a) lawful spouse;
- b) child(ren), in equal shares;
- c) parents, in equal shares;
- d) siblings, in equal shares.

If there is no surviving member of any of the above classes, the benefits will be paid to your estate.

Any payment that we make in good faith will fully discharge us to the extent of that payment.

The benefits can be paid in one lump sum or at your written request, in accordance with one of our available settlement plans. If you have not chosen any such settlement plan, the beneficiary can do so after your death. The beneficiary should request in writing to be paid from an available settlement plan. We must agree to the plan chosen.

**RIGHT OF RECOVERY** If payments for claims exceed the maximum amount payable under any benefit provisions or riders of the Policy, we have the right to recover the excess of such payments.

**PHYSICAL EXAMINATION AND AUTOPSY** At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

**LEGAL ACTIONS** No legal action may be brought to recover against the Policy within 60 days after written proof of loss has been given. No such action will be brought after three years from the time written proof of loss is required to be given.

## ACCIDENTAL INGESTION OF A CONTROLLED DRUG BENEFIT RIDER

**Securian Life Insurance Company**  
400 Robert Street North • St. Paul, Minnesota 55101-2098

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### Limited Benefit, Please Read Carefully

This Accidental Ingestion of a Controlled Drug Benefit Rider is a part of the Policy or Certificate to which it is attached. It is issued in consideration of the application and the continued payment of any required premium. This Rider applies to any Covered Person who was a Connecticut resident at the time his coverage became effective under this Rider.

Upon receipt of due proof of the Covered Person's accidental ingestion or consumption of a Controlled Drug, we will pay the benefit shown on the Schedule.

For purposes of this Rider, the following additional definition applies:


**CONTROLLED DRUG** means those drugs which contain any quantity of a substance which has been designated as subject to the federal Controlled Substances Act, or which has been designated as a depressant or stimulant drug pursuant to federal food and drug laws, or which has been designated by the Commissioner of Consumer Protection pursuant to Connecticut General Statute section 21a-243, as having a stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and as having a tendency to promote abuse or psychological or physiological dependence, or both.

Such Controlled Drugs are classifiable as amphetamine-type, barbiturate-type, cannabis-type, cocaine-type, hallucinogenic, morphine-type and other stimulant and depressant drugs. Specifically excluded from Controlled Drugs and controlled substances are alcohol, nicotine and caffeine.

This benefit will be paid in addition to any other benefits payable under the Policy or Certificate resulting from the same accident.

Benefits are subject to all terms and conditions of the Policy or Certificate. This Rider does not waive, alter or extend any provisions or limitations of the Policy or Certificate except to the extent shown above.

This Rider takes effect and ends concurrently with the Policy or Certificate to which it is attached.

  
Secretary

  
President

## Emergency Room and Ambulance Rider

### Securian Life Insurance Company

400 Robert Street North • St. Paul, Minnesota 55101-2098

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### Limited Benefit, Please Read Carefully

This Emergency Room and Ambulance Rider is a mandatory Rider that is made part of the Policy or Certificate to which it is attached. This Rider applies to any Covered Person who was a **Connecticut** resident at the time his coverage became effective under the Policy.

Upon receipt of due proof that a Covered Person incurred expenses for medical treatment received in a Hospital emergency room as a result of an Injury, we will pay the benefit shown on the Schedule.

Upon receipt of due proof that a Covered Person incurred expenses for ambulance transportation to a Hospital as a result of an Injury, we will pay the benefit shown on the Schedule. The benefit will be paid directly to the Ambulance provider rendering such service, if such provider has not received payment for such service from any other source. We shall not be required to provide benefits in excess of the maximum allowable rate established by the Connecticut Department of Public Health in accordance with Section 19a-177.

This benefit will not duplicate payments made under any other provision of the Policy or Certificate.

Benefits are subject to all the terms of the Policy or Certificate. This Rider does not waive, alter or extend any provisions or limitations of the Policy or Certificate except to the extent shown above.

This Rider takes effect and ends concurrently with the Policy or Certificate to which it is attached.

  
Secretary

  
President