

# YOUR GROUP PLAN



**Voluntary Accidental Death or Dismemberment**

**MetLife<sup>®</sup>**

University System of New Hampshire  
Dunlap Center-25 Concord Road  
Durham, New Hampshire 03824

TO OUR FACULTY/STAFF:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to University System of New Hampshire by Metropolitan Life Insurance Company.

University System of New Hampshire



Metropolitan Life Insurance Company  
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

A handwritten signature in black ink, appearing to read "C. Robert Henrikson".

C. Robert Henrikson  
President and Chief Operating Officer

Employer: **University System of New Hampshire**

Group Policy No.: **104112-G**

**Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.**

**For 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.**

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

**For Texas Residents:**

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # 512 - 475-1771

**PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:** This notice is for information only and does not become a part or condition of the attached document.

**Para Residentes de Texas:**

**AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # 512 - 475-1771

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU CERTIFICADO:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

**Arkansas residents please be advised of the following:**

**IMPORTANT NOTICE**

**IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:**

**1-800-638-5433**

**IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:**

**ARKANSAS INSURANCE DEPARTMENT  
CONSUMER SERVICES DIVISION  
1200 WEST THIRD  
LITTLE ROCK, ARKANSAS 72201-1904**

California residents please be advised of the following:

**IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT,  
CONTACT METLIFE AT:**

**METROPOLITAN LIFE INSURANCE COMPANY  
1 MADISON AVENUE  
NEW YORK, NY 10010  
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT  
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL  
THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY  
FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013  
1-800-927-4357 (within California)  
1-213-897-8921 (outside California)**

**Georgia residents please be advised of the following:**

**IMPORTANT NOTICE**

**The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.**

**Utah residents please be advised of the following:**

## **NOTICE TO POLICYHOLDERS**

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

### **PEOPLE ENTITLED TO COVERAGE**

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

### **POLICIES COVERED**

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

### **EXCLUSIONS AND LIMITATIONS**

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

## LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

## DISCLAIMER

### ***PLEASE READ CAREFULLY:***

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance  
Guaranty Association  
955 E. Pioneer Rd.  
Draper, Utah 84114

Utah Insurance Department  
State Office Building, Room 3110  
Salt Lake City, Utah 84114

**Virginia residents please be advised of the following:**

**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company  
1 Madison Avenue  
New York, New York 10010  
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23209

1-800-552-7945 - In-state toll-free  
1-804-371-9691 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

**Wisconsin residents please be advised of the following:**

**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.

Metropolitan Life Insurance Company  
Corporate Consumer Relations Department  
1 Madison Avenue  
New York, NY 10010  
1-800-638-5433

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 contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

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

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**SCHEDULE OF BENEFITS**  
**(Also see SCHEDULE SUPPLEMENT)**

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The following Benefits are provided subject to the provisions below.

<b><u>BENEFITS (EMPLOYEE ONLY)</u></b>	<b><u>AMOUNT</u></b>
<b>VOLUNTARY ACCIDENTAL DEATH OR DISMEMBERMENT</b>	
Option 1 .....	\$50,000
Option 2 .....	\$100,000
Option 3 .....	\$150,000

**IF YOU ARE AGE 70 OR OLDER**

The amount of your Voluntary Accidental Death or Dismemberment Benefits will be reduced by 50% on the date you reach age 70.

**WHEN YOU RETIRE**

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

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**SCHEDULE SUPPLEMENT**

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**A. Statements Made by You Which Relate to Insurability**

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

**B. Assignment**

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

**C. Additional Provisions**

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
  - a. to accept or to waive the required proof of a claim; nor
  - b. to extend the time within which a proof must be given to us.

Form G.23000-B1

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**DEFINITIONS OF CERTAIN TERMS USED HEREIN**

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**"Actively at Work" or "Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;
2. provided you are not disabled.

**"Covered Person"** means an Employee on whose account benefits are in effect under This Plan.

**"Doctor"** means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and
2. the service performed by the practitioner is within the scope of his or her license.

**"Employee"** means a person who is employed and paid for services by the Employer working 50% or more of a normal work week on a regular full or part-time basis.

**"Hospital"** means a facility which:

1. is legally licensed; and
2. is legally operated as a hospital; and
3. provides a broad range of 24 hour a day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of Doctors; and
4. provides 24 hour a day nursing care by, or under the direction of, a registered professional nurse (R.N.).

**"Personal Benefits"** mean the benefits which are provided on account of an Employee under This Plan.

**"This Plan"** means the Group Policy which is issued by us to provide Personal Benefits.

**"We", "us" and "our"** mean Metropolitan.

**"You" and "your"** mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

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## ELIGIBILITY FOR BENEFITS

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### Personal Benefits Eligibility Date

If you are an Employee on July 1, 2003, that is your Personal Benefits Eligibility Date.

If you become an Employee after July 1, 2003, your Personal Benefits Eligibility Date is the first day of the month after the date you become an Employee of the Employer.

Form G.23000-C

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## EFFECTIVE DATES OF PERSONAL BENEFITS

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### A. Making a Request for Benefits

1. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the Voluntary Accidental Death or Dismemberment benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

- a. when you are first eligible for Personal Benefits; and
- b. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the thirty-one day period following your Personal Benefits Eligibility Date; or
- b. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or

If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made during the annual enrollment period, as designated by the Employer and reported to you.

2. If you make a request to be covered for Personal Benefits within thirty days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Active Work Requirement.
3. If you make a request to be covered for Personal Benefits between thirty and sixty days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on the date of your request, subject to the Active Work Requirement.
4. If you make a request to change your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the first day of the month following the annual enrollment period, subject to the Active Work Requirement.

5. If you make your request, during an annual enrollment period, to increase your Personal Benefits to an option of the Plan providing the next higher level of benefits, evidence of your good health is not required. The increased amount of Personal Benefits will become effective on the first day of the month following the annual enrollment period, subject to the Active Work Requirement.
6. If you make a request, during an annual enrollment period, to decrease your Personal Benefits to an option of the Plan providing a lower level of benefits, the decreased amount of Personal Benefits will become effective on the first day of the month following the annual enrollment period.

**B. Active Work Requirement**

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

**C. Reinstatement of Benefits**

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

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**ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

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**A. Coverage**

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; and if:

1. that accident is the sole cause of the injury; and
2. that injury is the sole cause of that Covered Loss; and
3. that Covered Loss occurs not more than one year after the date of that accident.

In addition, we will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown below:

**1. Exposure Benefit**

We will pay an amount equal to the Full Amount, shown in section B, for the loss of your life if:

- a. such loss of life results from unavoidable exposure to the elements; and
- b. after one year, your body has not been found after the conveyance in which you were traveling:
  - i. disappeared;
  - ii. made a forced landing;
  - iii. sank; or
  - iv. was wrecked.

## 2. Seat Belt Benefit

We will pay an amount equal to 10% of the Full Amount shown in section B for the loss of your life that results from injuries sustained while driving or riding in a private Passenger Car if your Seat Belt was properly fastened; but the amount payable will not: (a) exceed \$25,000; nor (b) be less than \$1,000.

Passenger Car means any validly registered four-wheel private Passenger Car. It does not include:

- a. any commercially licensed car; or
- b. a private Passenger Car which is being used for commercial purposes.

"Seat Belt" means:

- a. any child restraint device which meets the definition of the state law; or
- b. any other restraint device which:
  - i. meets published federal safety standards;
  - ii. has been installed by the car manufacturer; and
  - iii. has not been altered after such installation.

The correct position of the Seat Belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.

We will not pay a Seat Belt Benefit if you were driving while under the influence of alcohol or drugs.

## 3. Hospital Benefit

If, as a result of an accident, you are confined in a Hospital, we will pay during such confinement, after a four day waiting period a monthly amount equal to 1% of the Full Amount shown in section B, but not more than \$2,500 per month.

In no case will such benefit be payable for:

- a. the first four days of a Hospital confinement; or
- b. more than 12 months during a period of Hospital confinement.

Payments for periods less than a full month will be made on a pro-rata basis.

## B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which you sustain in one accident not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits for which you are covered on the date of your accident.

### C. Table of Covered Losses and Benefit Amounts

<b>Covered Losses (Subject to Exclusions)</b>	<b>Benefit Amounts</b>
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	Full Amount
Thumb and Index finger of same hand	One-quarter of the Full Amount
Speech and hearing	Full Amount
Speech or hearing in both ears	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	One-half of the Full Amount
Hemiplegia	One-half of the Full Amount
Uniplegia	One-quarter of the Full Amount

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

Loss of thumb and index finger means actual severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and hearing means the entire and irrecoverable loss which has lasted continuously for 12 consecutive months following the injury.

Quadriplegia means total paralysis of both upper and lower limbs.

Paraplegia means total paralysis of both lower limbs.

Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

### D. Exclusions

We will not pay for any Covered Loss shown in Section C if it in any way results from, or is caused or contributed to by:

1. physical or mental illness, diagnosis of or treatment for the illness; or
2. suicide or attempted suicide; or
3. injuring oneself on purpose; or
4. the use of any drug or medicine, unless taken on the advice of a Doctor; or
5. a war, or a warlike action in time of peace; or

6. committing or trying to commit a felony or your being engaged in an illegal occupation; or
7. any poison or gas, voluntarily taken, administered or absorbed; or
8. service in the armed forces of any country or international authority, except the United States National Guard; or
9. operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or
10. driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

**E. Payment of Benefits**

The Accidental Death or Dismemberment Benefits for a Covered Loss will be paid when we receive notice and satisfactory proof of that loss.

Accidental Death or Dismemberment Benefits will be paid:

1. to your Beneficiary for the loss of your life; and
2. to you for any other Covered Loss sustained by you.

**F. Optional Types of Payment**

Payment of any amount of Accidental Death or Dismemberment Benefits for loss of life may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-4L

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**BENEFICIARY**

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**A. Your Beneficiary**

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

You may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

**B. More Than One Beneficiary**

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

**C. Death of a Beneficiary**

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or
2. that person dies at the same time your death occurs; or
3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

**D. No Beneficiary at Your Death**

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to one or more of the following persons who are related to you and who survive you:

1. spouse;
2. child;
3. parent;
4. brother and sister.

However, we may instead pay all or part of that amount to your estate.

Any payment will discharge our liability for the amount so paid.

Form G.23000-G

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**CLAIM PROCEDURE FOR  
ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

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**A. When Notice of Claim Must be Given**

Written notice of a claim must be given to us for Accidental Death or Dismemberment Benefits within 20 days after the date of the accident which caused the loss.

**B. Claim Forms**

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 15 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

**C. When Proof of Claim Must Be Given**

Written proof of a claim must be given to us not later than 90 days after the date of the loss, in the case of Accidental Death or Dismemberment Benefits.

**D. Late Notice or Proof**

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

**E. Time Limits on Starting Lawsuits**

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

**F. Medical Examinations**

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

**G. Autopsy**

If Accidental Death or Dismemberment Benefits are claimed, we, at our expense, have, in the case of death, the right to have an autopsy made where it is not against the law.

Form G.23000-H3

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**WHEN BENEFITS END**

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**A.** All of your benefits will end on the date your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may continue your benefits for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

**B.** If This Plan ends in whole or in part, your benefits which are affected will end.

**C.** If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

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**CONDITIONS UNDER WHICH YOUR ACTIVE  
WORK IS DEEMED TO CONTINUE**

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If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

**Your Sickness or Injury, Your Leave of Absence, Your Lay Off**

With respect to all Personal Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Form G.23000-L

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**NOTICES**

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This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

If you had coverage under a prior plan of benefits, please consult your Employer to determine if there are any additional provisions which affect your benefits under This Plan.

**Our Home Office is located at One Madison Avenue, New York, New York 10010.**

Form G.23000-E

# NOTES

# NOTES

**MetLife<sup>®</sup>**

Metropolitan Life Insurance Company  
One Madison Avenue, New York, NY 10010-3690