



**JEFFERSON PILOT
FINANCIAL**

Jefferson Pilot Financial Insurance Company
8801 Indian Hills Drive, Omaha NE 68114-4066
(402) 361-7300 A Stock Company

CERTIFIES THAT Group Policy No. GL 000010043327 has been issued to
County of Riverside
(The Group Policyholder)

The Issue Date of the Policy is July 1, 2002.

The insurance is effective only if the Employee is eligible for insurance and becomes and remains insured as provided in the Group Policy.

Certificate of Insurance for Class 1

You are entitled to the benefits described in this Certificate if you are eligible for insurance under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms.

A handwritten signature in cursive script, reading "David Spawcutter".

Chief Executive Officer

CERTIFICATE OF GROUP LIFE INSURANCE

SCHEDULE OF INSURANCE

CLASS 1

All Full-Time Employees Represented by LIUNA and SEIU that are Paid on a Per-Diem Basis, Employees of the Courts, and Deputy Public Defenders I, II, III, IV

WAITING PERIOD: None (For date insurance begins, refer to "Effective Dates of Coverages" section)

MINIMUM HOURS: 20 hours per week

LIFE INSURANCE

Amount of Personal Life Insurance

One times Basic Annual Earnings, rounded to the next higher \$1,000; subject to a maximum of \$50,000

Personal Life Insurance will be reduced as follows:

- At age 65, benefits will reduce by 35% of the original amount;
- At age 70, benefits will reduce an additional 25% of the original amount;
- At age 75, benefits will reduce an additional 15% of the original amount.

Benefits will terminate when you retire.

If you first enroll for Personal Life Insurance at age 65 or older, the above age reductions will apply to:

- Any Guarantee Issue Amount available without evidence of insurability; and
- The maximum amount of insurance for which you are eligible.

Basic Annual Earnings means your annual base salary or annualized hourly pay from the Employer before taxes on the determination date. The determination date is the last day worked just prior to the loss.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records or the amount for which premium has been paid, whichever is less.

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AMOUNT OF INSURANCE

The amount of your insurance is determined by the Schedule of Insurance in the Policy. The initial amount of coverage is the amount which applies to your class on the day your coverage takes effect. You may become eligible for increases in the amount of insurance in accord with the Schedule of Insurance. Any such increase will take effect on the latest of:

- (1) the first of the Insurance Month which coincides with or follows the date on which you become eligible for the increase; provided you are Actively at Work on that day;
- (2) the day you resume Active Work, if you are not Actively at Work on the day the increase would otherwise take effect; or
- (3) the day any required evidence of insurability is approved by the Company.

Any decrease will take effect on the day of the change; whether or not you are Actively at Work.

DEFINITIONS

ACTIVE WORK or **ACTIVELY AT WORK** means an employee's full-time performance of all customary duties of his or her occupation at:

- (1) the EMPLOYER'S place of business; or
- (2) any other business location where the employee is required to travel.

Unless disabled on the prior workday or on the day of absence, an employee will be considered Actively at Work on the following days:

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) an excused or emergency leave of absence (except a medical leave).

COMPANY means Jefferson Pilot Financial Insurance Company, a Nebraska corporation, whose Home Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means at 12:01 A.M., Standard Time, at the Group Policyholder's place of business; when used with regard to eligibility dates and effective dates. It means 12:00 midnight, Standard Time, at the same place; when used with regard to termination dates.

EMPLOYER means the Group Policyholder or the Participating Employer named on the Face Page.

FULL-TIME EMPLOYEE means an employee of the EMPLOYER:

- (1) whose employment with the EMPLOYER is the employee's principal occupation;
- (2) who is not a temporary or seasonal employee; and
- (3) who is regularly scheduled to work at such occupation at least the number of hours as shown in the Schedule of Insurance.

INSURANCE MONTH means:

- (1) that period of time beginning on the Issue Date of the Policy and extending for one month; and
- (2) each subsequent month beginning on the same day after that.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

POLICY means the Group Insurance Policy issued by the Company to the Group Policyholder. A copy of the Policy may be examined upon request at the Home Office of the Group Policyholder.

ELIGIBILITY

If you are a Full-Time Employee and a member of an employee class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

- (1) the Policy's date of issue; or
- (2) the day you complete the Waiting Period.

WAITING PERIOD. (See Schedule of Insurance).

EFFECTIVE DATES OF COVERAGES

Your insurance is effective on the latest of:

- (1) the day you become eligible for the coverage;
- (2) the day you resume Active Work, if you are not Actively at Work on the day you become eligible;
- (3) the day you make written application for coverage; and sign:
 - (a) a payroll deduction order, if you pay any part of the premium; or
 - (b) an order to pay premiums from your Section 125 Plan account, if Employer contributions are paid through a Section 125 Plan; or
- (4) the day the Company approves your coverage, if evidence of insurability is required.

Evidence of insurability is required if:

- (1) you apply for coverage more than 31 days after you become eligible; or
- (2) you make written application to re-enroll for coverage after you have requested:
 - (a) to cancel your coverage;
 - (b) to stop payroll deductions for the coverage; or
 - (c) to stop premium payments from your Section 125 Plan account.

EXCEPTION. If your coverage terminates due to an approved leave of absence or a military leave, any Waiting Period or evidence of insurability requirement will be waived upon your return; provided:

- (1) you return within six months after the leave begins;
- (2) you apply or are enrolled within 31 days after resuming Active Work; and
- (3) the reinstated amount of insurance does not exceed the amount which terminated.

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

- (1) the day the Policy terminates;
- (2) the last day of the Insurance Month in which you request termination;
- (3) the last day of the period for which the premium for your insurance has been paid;
- (4) the day you cease to be a member of an employee class shown in the Schedule of Insurance;
- (5) with respect to any particular insurance benefit, the day the part of the Policy providing that benefit terminates;
- (6) the day your employment with the Employer terminates; or
- (7) the day you enter the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

Ceasing Active Work terminates your eligibility. However, it may be possible to continue all or part of your insurance during a temporary layoff, leave of absence or military leave; or while you are unable to work due to sickness or injury. The conditions concerning such a continuance may be found in the Policy. See your Employer for this information.

If your eligibility ends because you cease Active Work due to a labor dispute, and your Employer's premium contributions are required by a collective bargaining agreement; then arrangements may be made with the Employer to continue insurance (except for any Weekly Disability Income Insurance) for up to six months, subject to:

- (1) the conditions shown in the Policy; and
- (2) payment of the required premium by at least 75% of the Insured Persons eligible to continue. (See your Employer for further information.)

DEATH BENEFIT

Upon receipt of satisfactory proof of your death, the Company will pay a death benefit equal to the amount of Personal Life Insurance in effect on the date of your death. The benefit will be paid in accord with the Beneficiary section. Arrangements may be made to have this death benefit paid in installments.

BENEFICIARY

Your Beneficiary is the person or persons named on your enrollment card. The Beneficiary may be changed in accord with the terms of the Policy. If you have not named a Beneficiary, or if no named Beneficiary is living when you die; then the death benefit will be paid to your:

- (1) surviving spouse; or, if none
- (2) surviving child or children in equal shares; or, if none
- (3) surviving parent or parents in equal shares; or, if none
- (4) surviving brothers and sisters in equal shares; or, if none
- (5) estate, or in accord with the Facility of Payment section of the Policy.

LIVING BENEFIT

BENEFIT. The Living Benefit is an advance payment of part of your Personal Life Insurance. If you become Terminally Ill, it may be paid to you in a lump sum, once during your lifetime. To qualify you must:

- (1) have satisfied the Active Work requirement under the Policy;
- (2) have been insured under the Policy for at least 12 months;
- (3) have qualified for the Extension of Death Benefit under the Policy; and
- (4) have at least \$2,000 of Personal Life Insurance under the Policy on the day before the Living Benefit is paid.

Receiving the Living Benefit will reduce the Death Benefit payable at your death, as shown on the next page.

"Terminally Ill" means you have a medical condition which is expected to cause your death within 12 months, despite appropriate medical treatment.

APPLYING FOR THE LIVING BENEFIT. To withdraw the Living Benefit, you (or your legal representative) must send the Company:

- (1) written election of the Living Benefit, on forms supplied by the Company; and
- (2) satisfactory proof that you are Terminally Ill, including a Physician's written statement.

The Company reserves the right to decide whether such proof is satisfactory. The Company may have you examined, at its own expense, by one or more Physicians of its choice.

Before paying a Living Benefit, the Company must also receive the written consent of any irrevocable beneficiary, assignee or bankruptcy court with an interest in the benefit. (See Limitations 5, 6 and 7.)

AMOUNT OF THE LIVING BENEFIT. You may elect to withdraw a Living Benefit in any \$1,000 increment; subject to:

- (1) a minimum of \$1,000 or 10% of your amount of Personal Life Insurance (whichever is greater); and
- (2) a maximum of \$250,000 or 75% of your amount of Personal Life Insurance (whichever is less).

To determine the Living Benefit, the Company will use the lesser of A or B below:

- A. the amount of your Personal Life Insurance which is in force on the day before the Living Benefit is paid; or
- B. the amount of your Personal Life Insurance which would be in force 12 months after that date; if your coverage is scheduled to reduce, due to age, within 12 months after the Living Benefit is paid.

Before making payment to you, the Company will reduce the Living Benefit by an early withdrawal fee. This early withdrawal fee will be 12 months' interest at the lesser of:

- (1) the annual interest rate the Company then charges on policy loans under its nonvariable individual life insurance policies;
- (2) the annual discount rate any applicable state law then permits for accelerated death benefits under life insurance contracts; or
- (3) the annual discount rate federal income tax regulations then permit for qualified accelerated death benefits under life insurance contracts.

EFFECT ON AMOUNT OF LIFE INSURANCE. "Remaining Life Insurance" means the amount of Personal Life Insurance which remains in force on your life after a Living Benefit is paid. Your Remaining Life Insurance will equal:

- (1) the amount of your Personal Life Insurance which was used to determine your Living Benefit (A or B on the prior page); minus
- (2) any percentage by which your coverage is scheduled to reduce, due to age; if the reduction occurs more than 12 months after the Living Benefit is paid, and while you are still living; minus
- (3) the amount of the Living Benefit withdrawn (including the early withdrawal fee retained by the Company).

CONDITIONS. If you exercise the Conversion Privilege after a Living Benefit is paid, the amount of the conversion policy will not exceed the amount of your Remaining Life Insurance. If you have Accidental Death and Dismemberment benefits under the Policy, your Principal Sum will not be affected by the payment of a Living Benefit.

EFFECT ON DEATH BENEFIT. If you die after receiving a Living Benefit, the amount of Remaining Life Insurance in force on the date of your death will be paid as a Death Benefit. Payment will be made in accord with the Beneficiary section of the Policy.

If you die after applying for a Living Benefit, but before the Company has made payment; then your request will be void and no Living Benefit will be paid. The amount of Personal Life Insurance in force on the date of your death will be paid in accord with the Beneficiary section of the Policy.

EFFECT ON TAXES AND GOVERNMENT BENEFITS. Any Living Benefit amount withdrawn may be taxable income to you. Receipt of the Living Benefit may also affect your eligibility for Medicaid, Supplemental Security Income and other government benefits. You should consult your own tax and legal advisor before applying for a Living Benefit. The Company is not responsible for any tax owed or government benefit denied, as a result of the Living Benefit payment.

LIMITATIONS. No Living Benefit will be paid:

- (1) if the Policy does not include an Extension of Death Benefit provision;
- (2) if any required premium is due and unpaid;
- (3) on any Dependent Life Insurance under the Policy;
- (4) on any conversion policy purchased in accord with the Conversion Privilege;
- (5) without the written approval of the bankruptcy court, if you have filed for bankruptcy;
- (6) without the written consent of the beneficiary, if you have named an irrevocable beneficiary;
- (7) without the written consent of the assignee, if you have assigned your rights under the Policy;
- (8) if any part of your Personal Life Insurance must be paid to your child, spouse or former spouse; pursuant to a legal separation agreement, divorce decree, child support order or other court order;
- (9) if you are Terminally Ill due to a suicide attempt, while sane or insane; or due to an intentionally self-inflicted injury;
- (10) if a government agency requires you to use the Living Benefit to apply for, receive or continue a government benefit or entitlement; or
- (11) if you have previously received a Living Benefit under the Policy.

CONVERSION PRIVILEGE

If your insurance or insurance on a Dependent terminates for any reason except:

- (1) termination or amendment of the Policy; or
- (2) your request for:
 - (a) termination of insurance; or
 - (b) cancellation of your payroll deduction,

an individual life policy, known as a conversion policy, may be purchased without evidence of insurability.

To purchase a conversion policy, application and payment of the first premium must be made within 31 days after the life insurance is terminated.

The conversion policy will:

- (1) be in an amount not to exceed the amount of life insurance which was terminated;
- (2) be on any form (except term) then issued by the Company at the age and amount for which application is made;
- (3) be issued at the person's age at nearest birthday;
- (4) be issued without disability or other supplemental benefits; and
- (5) require premiums based on the class of risk to which the person then belongs.

A conversion policy also may be purchased if:

- (1) all or part of your insurance or insurance on a Dependent terminates due to amendment or termination of the Policy; and
- (2) you have been covered continuously under the Policy for at least 5 years or you are Totally Disabled (as defined by the Policy).

The amount of the conversion policy may not exceed the lesser of:

- (1) \$3,000 (not applicable if you are Totally Disabled); or
- (2) the amount of life insurance which terminates, less the amount of any group life insurance for which the person becomes eligible within 31 days after the termination.

The conversion policy will take effect on the later of:

- (1) its date of issue; or
- (2) 31 days after the date the insurance terminated.

If death occurs during the 31 day conversion period, the Company will pay the life insurance which could have been converted even if no one applied for the conversion policy.

When your insurance terminates, written notice of your right to convert will be given to you.

If written notice is not given to you at least 15 days before the end of the 31 day conversion period, an additional period in which to convert will be granted. Any such extension of the conversion period will expire on the earliest of:

- (1) 25 days after you are given the written notice; or
- (2) 60 days after the end of the 31 day conversion period, even if you are never given such notice.

No death benefit will be payable under the Policy after the 31 day conversion period has expired even though the right to convert may be extended.

**CLAIMS PROCEDURES
FOR LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

NOTE: The Policy may include an Extension of Death Benefit, an Accelerated Death Benefit or a Living Benefit. If so, please refer to that section for special claim procedures.

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of an accidental death or dismemberment claim must be given within 20 days after the loss occurs; or as soon as reasonably possible after that.* The notice must be sent to the Company's Home Office. It should include:

- (1) your name and address; and
- (2) the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you or your Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of the loss; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. In addition to the information requested on the claim form, documentation must include:

- (1) A certified copy of the death certificate, for proof of death.
- (2) A copy of any police report, for proof of accidental death or dismemberment.
- (3) A signed authorization for the Company to obtain more information.
- (4) Any other items the Company may reasonably require in support of the claim.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have you examined:

- (1) by a Physician of the Company's choice;
- (2) as often as reasonably required.

If you fail to cooperate with an examiner or fail to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE

Death. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment and Settlement Options sections of the Policy. If the Policy includes Dependent Life Insurance; then any benefits payable for an insured Dependent's death will be paid to:

- (1) you, if you survive that Dependent; or
- (2) your Beneficiary, or in accord with the Facility of Payment section; if you do not survive that Dependent.

Dismemberment. If the Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than your death benefit, will be paid to you.

CLAIMS PROCEDURES (Continued)

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) whether more information is needed to support the claim; and
- (3) how the claimant may request a review of the decision by the Company, or by the state Department of Insurance. It will include the address and phone number of their consumer complaint unit.

The Company will send this notice within 15 days after it receives complete proof of claim and enough information to determine liability. If reasonably possible, the Company will send it within:

- (1) 90 days after receiving the first proof of a death or dismemberment claim; or
- (2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected. In any event, the Company must send written notice of its decision within:

- (1) 180 days after receiving the first proof of a death or dismemberment claim; or
- (2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:

- (1) 60 days after receiving a denial notice of a death or dismemberment claim; or
- (2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy, the notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

CLAIMS PROCEDURES (Continued)

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

- (1) the special circumstances which require the delay;
- (2) whether more information is needed to review the claim; and
- (3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

- (1) reduce future benefits until full reimbursement is made; and
- (2) recover such overpayments from you, or from your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to:

- (1) manage the Policy and administer claims under it; and
- (2) interpret the provisions and resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering the Policy and claims under it;
- (2) determine your eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to your or your Beneficiary's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

CERTIFICATE AMENDMENT

TO BE ATTACHED TO THE CERTIFICATE FOR GROUP POLICY NO.: 000010043327

ISSUED TO: County of Riverside

Your Certificate is amended by the addition of the following provisions.

**PRIOR INSURANCE CREDIT UPON TRANSFER OF
LIFE INSURANCE CARRIERS**

This provision prevents loss of life insurance coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group life insurance policy, which the Policy replaced within 1 day of the prior plan's termination date.

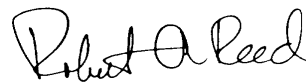
FAILURE TO SATISFY ACTIVE WORK RULE. Subject to payment of premiums, the Policy will provide life coverage if you:

- (1) were insured under the prior plan on its termination date;
- (2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date;
- (3) are not entitled to any extension of life insurance under the prior plan; and
- (4) are not Totally Disabled (as defined in the Extension of Death Benefit section of the Policy) on the date the Policy takes effect.

AMOUNT OF LIFE INSURANCE. Until you satisfy the Policy's Active Work rule, the amount of your group life insurance under the Policy will not exceed the amount for which you were insured under the prior plan on its termination date.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains the same.

Jefferson Pilot Financial Insurance Company



Officer of the Company

**CALIFORNIA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER**

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these type of insurance are members of the California Life and Health Insurance Guaranty Association ("CLHIGA"). 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 through the Association is not unlimited, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guaranty Association may not provide coverage for the policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the 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.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life & Health Insurance Guaranty Association P.O. Box 17319 Beverly Hills, CA 90209-3319	or	Consumer Services Division California Department of Insurance 300 South Spring Street Los Angeles, CA 90013
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The state law that provides for this safety-net coverage is called the California 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 Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guaranty Association if they live in this state and hold a life or health 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 this Guaranty Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), 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;
- 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 Guaranty Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contractholders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- 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;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the life insurance company would owe under a life policy or annuity contract up to
- \$100,000 in cash surrender values,
- \$100,000 in present value of annuities; or
- \$250,000 in life insurance death benefits.
- A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.



JEFFERSON PILOT
FINANCIAL

PRIVACY PRACTICES NOTICE

The Jefferson Pilot Financial companies* are concerned about your privacy. In order to issue and service high quality financial products and services, we collect personal information about you. **We do not sell your information to third parties**, and we disclose your personal information only as necessary to provide the products and services you expect from a financial services leader. **This summary of our practices is provided for your information. You do not need to take any action as a result of this notice, but you do have certain rights as describe below.**

Collecting Information. To conduct our business, we may collect nonpublic personal information about you from:

- applications or other forms, such as name, address, Social Security number, assets and income, employment status and dependent information;
- your transactions with us, our affiliates, or with others, such as account activity, payment history, and products and services purchased;
- consumer reporting agencies, such as credit relationships and credit history. These agencies may retain their reports and share them with others who use their services;
- other individuals, businesses and agencies, such as motor vehicle reports, and medical and demographic information; and
- visitors to our websites, such as information from on-line forms, site visitorship data and on-line information collecting devices commonly called "cookies."

We do not collect medical or health information, nor do we request financial information from consumer reporting agencies, on our mutual fund and brokerage consumers.

How We Treat the Information. Within Jefferson Pilot Financial we restrict access to nonpublic personal information about you to those employees who need to know that information to provide our products or services or to otherwise conduct our business, including actuarial or research studies. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to safeguard all your nonpublic personal information. We may also disclose all of the information described above to third parties with which we contract for services. We contractually require these third parties to protect your information. Examples of these third parties are:

- financial service providers, such as third party administrators, broker-dealers, insurance agents and brokers, investment companies, registered representatives, investment advisors, companies that perform marketing services on our behalf or on behalf of Jefferson Pilot Financial and another financial institution, or to other financial institutions with whom we have joint marketing agreements; and
- non-financial companies and individuals, such as our consultants and vendors and the Medical Information Bureau.

In addition, we may disclose your nonpublic personal information to medical care institutions or medical professionals, insurance regulatory authorities, law enforcement or other government authorities, or to affiliated or nonaffiliated third parties as reasonably necessary to conduct our business or as otherwise permitted by law.

Our privacy procedures apply even after you stop having any customer relationship with Jefferson Pilot Financial.

We retain the right to use ideas, concepts, know-how, or techniques contained in any nonpublic personal information you provide to us for our own purposes, including developing and marketing products and services.

We do not disclose to our affiliates any information we receive about you from a consumer reporting agency.

We do not disclose your nonpublic personal information to third parties except as necessary to provide you our products and services. You do have the right to review the personal information about you relating to any insurance or annuity product issued by us that we can reasonably locate and retrieve. You also can request that we correct, amend or delete any inaccurate information. If you wish to do this, please write Attn: Privacy Inquiry, to the address you normally use for your correspondence with us. If you don't have that address, write to: Jefferson Pilot Financial, Attn: Client Services Department-Privacy, P.O. Box 21008, Greensboro, NC 27420, describe the information you wish to see and enclose payment for our \$25.00 handling fee.

*This Notice applies for the following Jefferson Pilot Financial companies:

Allied Professional Advisors, Inc.	Jefferson Pilot LifeAmerica Insurance Company	Jefferson Pilot Variable Corporation
Hampshire Funding, Inc.	Jefferson-Pilot Life Insurance Company	Polaris Advisory Services, Inc.
Jefferson Pilot Securities Corporation	Jefferson Pilot Financial Insurance Company	Westfield Assigned Benefits Company