TERM LIFE CERTIFICATE
FOR
ONEIDA NATION

Please read this certificate, including all endorsements, if any, carefully, so you know and understand your coverage.

This certificate is not the contract of insurance. It is merely evidence of insurance provided under the group term life insurance policy (hereinafter called "group policy" or "policy") issued by The EPIC Life Insurance Company (EPIC) to the group policyholder (hereinafter called "group policyholder" or "policyholder"). This certificate describes the essential features of such insurance. This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to you prior to the effective date of this certificate.

The policy is issued by EPIC and delivered to the policyholder. All terms, conditions and all other provisions of the policy are governed by the laws of Wisconsin. All benefits are provided in accordance with the terms, conditions, exclusions, limitations and provisions of the policy, including all endorsements, if any, attached to this certificate, and applicable laws and regulations of the State of Wisconsin.

THE EPIC LIFE INSURANCE COMPANY

Michael F. Hamerlik

Michael F. Hamerlik, President

E12082-088-1907

TABLE OF CONTENTS

GENERAL INFORMATION

General Description of Coverage

EPIC certifies that a group policy has been issued to Oneida Nation insuring certain members of the group. We call the group the policyholder. Those persons to whom we've issued certificates are called covered members. The group policy forms a contract between us and the policyholder, in which the policyholder is responsible for 100% of the premium for its enrolled members. We'll provide the insurance described here under the terms, conditions and provisions of that contract. Subject to that contract, each member is insured for the coverage described in this certificate. Please see subsection “Entire Contract”.

Coverage

Coverage is subject to terms, conditions, exclusions, limitations, and all other provisions of the policy. As a certificate, this document describes the essential features of the insurance provided by the policy, but does not constitute the actual policy. **You may examine the policy at the office of the policyholder during regular business hours. To make an appointment, please contact the Trust Enrollment Department at (920) 490-3930.**

This certificate replaces and supersedes all certificates and endorsements thereto which we may have previously issued to the covered employee prior to the effective date of this certificate.

How to Use This Certificate

This certificate, including all endorsements, should be read carefully and completely by you. You should also review this certificate periodically. The provisions of this certificate are interrelated. This means that each provision is subject to all of the other provisions. Therefore, reading just one or two provisions may not give you a clear or full understanding of your coverage under the policy.

Each term used in this certificate has a special meaning. These terms are defined for you in section “Definitions”. By understanding these definitions, you will have a clearer and better understanding of your coverage under the policy as described in this certificate by us.

From time to time the policy may be amended by us. When that happens, a new endorsement for this certificate will be sent by us to the policyholder for its delivery to each covered member. That means your coverage under the policy will change to the extent described in the endorsement, as of the effective date of that endorsement. This certificate should be kept in a safe place for your future reference.

Payment of Benefits

EPIC has the sole and exclusive right to interpret and apply the policy's terms, conditions, limitations, exclusions, and all other provisions of the policy, including, but not limited to, making factual determinations under the policy's provisions, including, but not limited to, whether benefits are payable. At any time, we may, at our sole discretion, give certain discretionary authority to other persons or entities providing administrative services to us in regard to the policy. We reserve the right to change, interpret, modify, remove or add benefits, or terminate the policy, at our sole discretion, without giving prior notice to you, or getting your approval. Other than EPIC, no person or entity has any authority to make any oral changes or amendments to the policy. Please also see subsection “Waiver and Change.”

We may, at our sole discretion, arrange for various persons or entities to provide administrative services in regard to the policy, including claims processing services. Their identity and the nature of the services being provided by them may be changed by us at any time at our sole discretion, and without giving prior notice to you, or getting

your approval. By accepting this certificate, the policyholder agrees to and must cooperate fully with those persons or entities in the performance of their responsibilities.

DEFINITIONS

In this certificate the following terms shall mean:

Certificate: the document issued by us to the policyholder and disseminated to you is not a contract of insurance, but only evidence of coverage, and describes the essential features of the insurance provided by the policy.

Covered Member: an enrolled member for whom we've accepted the appropriate premium paid by the policyholder.

Eligible Member: a person who meets the membership criteria stated in the Constitution and By Laws for the Oneida Nation.

Enrolled Member: an eligible member who has applied for membership in the Oneida Nation and who has been approved as an enrolled member by the policyholder.

Enrollment Date: the effective date of coverage under the policy.

EPIC: The EPIC Life Insurance Company with its principal office located in Madison, Wisconsin.

Group Master Policy/Policy: the insurance policy issued by us to Oneida Nation known as the group policyholder. In it, we agree to insure members of the group policyholder for future losses covered by the policy through benefit payments, subject to the terms, conditions, and provisions of the policy.

Illness or Sickness: a disturbance in a function, structure or system of the human body which causes one or more physical signs and/or symptoms and which, if left untreated, will result in deterioration of the health state of the function, structure or system of the human body.

Injury: an injury that is sustained by you which is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurs while the insurance coverage is in force.

Legal Guardian: a person lawfully invested and charged with the obligation of taking care of managing the property and rights of another person who is unable to do so himself/herself due to age, understanding, lack of self-control, or competency and who is therefore deemed incapable of managing his/her own affairs.

Legal Representative: a personal representative who stands in place of and represents another either by consent or court appointment. Examples include written authorization, Power of Attorney, guardianship or an attorney/client relationship.

Member: an individual who is an enrolled Tribal member of the Oneida Nation.

Physician: a person who received a degree in medicine from an accredited college or university and is a medical doctor or surgeon licensed by the state in which he/she is located and provides health care services while he/she is acting within the lawful scope of his/her license. When we are required by law to cover the services of any other licensed medical professional under the policy, a physician also includes such other licensed medical professional who: (1) is licensed by the state in which he/she is located; (2) is acting within the lawful scope of his/her license.

Policyholder: Oneida Nation.

We, us, our: The EPIC Life Insurance Company.

You, your: a covered member.

MEMBER EFFECTIVE DATES

If required premium for an enrolled member is submitted to EPIC, the effective date of coverage to be issued under the policy for that enrolled member shall be determined as follows:

Initial Enrollees

An initial enrollee is an enrolled member at the time of the policyholder's initial enrollment period with EPIC. An initial enrollee's effective date shall be the policy's effective date.

New Members

A new member's effective date of coverage under the policy will be the date the eligible member is approved by the policyholder as an enrolled member of the Oneida Nation.

If you relinquish your membership and later wish to reapply as a member, you will be considered a new member and your effective date will be as stated above.

WHEN YOUR COVERAGE ENDS

As determined by us, your coverage under the policy shall end automatically without notice at midnight central standard time (CST) at the main office of the policyholder on the earliest of the following dates:

1. The date the policy ends;

2. The day immediately following the last day of the calendar month for which premium required for your coverage has been paid to us in accordance with the policy;

3. The day immediately following the last day of the calendar month in which you request that your coverage terminate;

4. The date you relinquish your membership in the Oneida Nation;

5. The date you die; or

6. The day immediately following the date you are no longer an enrolled member.

BENEFITS

Living Benefit

1. Definitions.

The following definitions apply to this subsection only:

Administrative Fee: $300. This amount is the administrative cost to EPIC in processing the accelerated/living benefit.

Terminal Condition: an irreversible condition caused by illness or injury which, in the documented medical judgment of a physician will directly result in a life expectancy of 12 months or less for you, as determined by us.

2. Benefits.

This subsection provides for the payment of a portion of the death benefit under the policy.

If you are diagnosed with a terminal condition, you or your legal representative while you are living may request the living benefit to be paid to you. To receive this benefit:

a. your coverage must be in force under the policy and all premiums due must be fully paid;

b. you must have a beneficiary designation form on file with the policyholder;

c. a living benefit request form must be completed by you or your legal representative and submitted to us;

d. we must receive a signed written acknowledgment and agreement from any assignee or irrevocable beneficiary agreeing to our payment of the living benefit to you in accordance with this subsection; and

e. the information we have meets all of the requirements set forth in the policy.

If you have a medically approved terminal condition, we will pay up to $7,500 of the death benefit, less the $300 administrative fee.

Premium payments for your coverage(s) must be continued to be paid to us on the full amount of the death benefit.

The exercise of your rights under this subsection is limited to one time only. Only one living benefit can be paid to you.

Payment of any living benefit, including the applicable discount, will reduce your term life benefits available under subsection "Term Life Coverage" and the amount available for you to convert to a conversion policy of life insurance as stated in subsection "Conversion Privilege".

Any living benefit payment paid to you may be considered as taxable income to you. Your situation may be different and any questions on this subject should be discussed with your tax advisor. EPIC is not liable for any tax or tax penalty which may arise as a result of any living benefit payment made pursuant under this subsection.

3. Payment of Benefits.

In order to receive payment of a living benefit as stated in paragraph 2. above, you must submit to us: (a) the completed living benefit request form; and (b) any additional information requested by us. Payment will be made in accordance with paragraph 2. above to you within 60 days following our receipt of a completed living benefit request form and our determination that a living benefit is payable to you in accordance with this subsection.

4. Exclusions.

A living benefit does not apply and is not payable in any of the following situations:

a. to your intentionally self-inflicted illness, injury, or suicide attempt;

b. if your required premiums for coverage under this policy is due and unpaid;

c. if you have irrevocably assigned the applicable life benefit payable under the policy;

d. when all or a portion of the applicable life benefits payable under the policy are paid as part of a divorce settlement;

e. if you are: (1) required by law to use the living benefit to satisfy the claims of creditors, whether in bankruptcy or otherwise; or (2) required by a government agency to use this benefit to apply for, obtain or keep a government benefit or entitlement.

Term Life Coverage

1. Your Benefits.

The benefit payable for term life coverage is $15,000 for an enrolled member.

The benefit amount stated above may be reduced by any benefit payable under subsection "Living Benefit".

2. Payment of Benefit.

a. Covered Members Age 18 and Over. We will pay a benefit in the amount of coverage stated above at the time of your death to your beneficiary(ies) (if more than one beneficiary is designated, benefit will be divided equally among any surviving beneficiaries, unless otherwise specified) if we receive a completed claim form, and all other information that we need to determine our liability to pay any benefit under the policy, including, but not limited to, medical records, accident reports, autopsy results, and other reports.

If a beneficiary is not named on a beneficiary designation form or in any other manner prearranged by us as acceptable and on file with the policyholder, we will determine the beneficiary and pay benefits to the first available individual or individuals using the following naming sequence:

(1) surviving spouse; or, if none

(2) surviving children (natural children or legally adopted) in equal shares; or if none

(3) surviving grandchild or grandchildren in equal shares; or, if none

(4) surviving parent(s) in equal shares; or if none

(5) surviving brother(s) and sister(s) in equal shares; or, if none

(6) death benefits will be paid to the Oneida Nation OLIPP Stabilization Fund if there are no survivors in (1) through (5) above.

b. Covered Members Under Age 18. We will determine the beneficiary and pay benefits to the first available individual or individuals using the following naming sequence:

(1) surviving spouse; or, if none

(2) surviving children (natural children or legally adopted) in equal shares; or, if none

(3) surviving legal guardian(s) in equal shares; or, if none

(4) surviving parent(s) in equal shares; or, if none

(5) surviving brother(s) and sister(s) in equal shares; or if none

(6) surviving grandparent(s) in equal shares; or if none

(7) death benefits will be paid to the Oneida Nation OLIPP Stabilization Fund if there are no survivors in (1) through (6) above.

Benefits are paid in a lump sum to the designated beneficiary as indicated in our records. However, other arrangements for a different mode of payment may be made subject to our prior written approval.

PAYMENT OF LIVING BENEFIT CLAIMS

How to File Claims

Before benefits are paid by us, we must be given written proof of claim as described below. In the event of your incapacity, your legal representative must comply with the "Proof of Claim" subsection. Benefits payable under the policy will be paid as soon as reasonably possible after we receive the written proof of claim required to be submitted to us in accordance with subsection "Proof of Claim" below. We will decide whether benefits are payable on the claims submitted to us within a reasonable period of time after we receive the written proof of claim described in subsection "Proof of Claim" below, which allows us to make an informed decision as to whether benefits are payable.

If the claim is denied in whole or in part, you will receive a written notice from us with: (1) the specific reason(s) on which denial or partial denial is based; (2) the specific reference(s) to the policy provisions on which denial or partial denial is based; (3) a description of additional material or information which may be necessary for you to perfect your claim and an explanation of why such material or information is necessary; and (4) an explanation of how you may have the claim reviewed by us if you do not agree with our denial or partial denial.

If you want to appeal the denial, such an appeal must be made in accordance with section GENERAL PROVISIONS / Claim Review Procedures below.

Proof of Claim

1. Written proof of your claim includes: (a) the completed claim form submitted to us from the covered member or their legal representative; (b) legal representative power of attorney, if required; and (c) all other information that we need to determine our liability to pay benefits under the policy, including, but not limited to, medical records and other reports.

2. The claim form must be completed and signed. A physician must complete and sign that portion of the claim form.

3. The completed and signed claim form must be forwarded to us by the covered member or their legal representative.

PAYMENT OF TERM LIFE CLAIMS

How to File Claims

Before benefits are paid by us, we must be given written proof of claim. Benefits payable under the policy will be paid as soon as reasonably possible after we receive the written proof of claim required to be submitted to us by the policyholder in accordance with subsection "Proof of Claim". We will decide whether benefits are payable on the claims submitted to us within a reasonable period of time after we receive the written proof of claim described in subsection "Proof of Claim", which allows us to make an informed decision as to whether benefits are payable.

Any benefits paid by us in accordance with the policy shall fully discharge us from all further liability to the extent of benefits paid.

If there are circumstances which require that we have more time to determine our liability to pay benefits on such claim, we will send your beneficiaries written notice within 30 days of our receipt of such proof of claim, explaining why we need more time to review the charges. In that case, our decision on the claim will then be made within 120 days of our receipt of such proof of claim.

If the claim is denied in whole or in part, your beneficiaries will receive a written notice from us with: (1) the specific reason(s) on which denial or partial denial is based; (2) the specific reference(s) to the policy provisions on which denial or partial denial is based; (3) a description of additional material or information which may be necessary to perfect the claim and an explanation of why such material or information is necessary; and (4) an explanation of how the claim may be reviewed by us if the beneficiaries do not agree with our denial or partial denial.

If your beneficiaries want to appeal the denial, such an appeal must be made in accordance with section GENERAL PROVISIONS /Claim Review Procedures below.

Proof of Claim

1. Your beneficiaries should contact the policyholder to provide their contact information. Contact with the policyholder should be made within 90 days after a loss occurs, but not later than one year after the date of loss. Written proof of claim includes: (a) the completed claim form required by us; (b) the certified death certificate and/or registered documentation recognized by the government in which the death occurred; and (c) all other information that we request to determine our liability to pay benefits under the policy, including, but not limited to, medical records and other reports.

2. The claim form must be completed and signed.

3. The completed and signed claim form should be provided within 90 days after the date of loss, but no later than one year after the date of loss. However, if it is not reasonably possible to submit written proof of claim within this time period, we will still process the claim according to the terms of the policy as long as our ability to process the claim is not compromised by such delay.

GENERAL PROVISIONS

Beneficiary for Enrolled Members Age 18 or Over

If you are age 18 or over, at least one beneficiary must be designated on the Beneficiary Designation Form. Only you can designate a beneficiary. You may change a beneficiary at any time by sending the policyholder a written request for the change. The written request for change must be sent to the Oneida Trust Enrollment Department. No change will become effective unless the Oneida Trust Enrollment Department receives the request. Any beneficiary change will be effective on the date the Oneida Trust Enrollment Department receives your signed request, unless otherwise specified in the request. If you die before the policyholder receives the request, the change will not be effective. Once proceeds have been paid, our obligations under the policy will have been met and we will not be obligated to alter or change the payment.

If you name more than one beneficiary, available benefits, if any, will be divided equally among any surviving beneficiaries, unless otherwise requested by you in your beneficiary designation.

If your coverage(s) is reinstated in accordance with the provisions of the policy, any previous beneficiary designations will no longer be in effect. A new beneficiary designation form must be completed and submitted to the policyholder.

Facility of Payment

If any benefits are payable to a person who is under the age of 18 years or to a person who is not legally competent to execute a valid receipt, then our payment of benefits will be made to: (1) that person's duly-appointed legal guardian; or (2) if no legal guardian has been appointed, to another legal representative of that person; or (3) an individual who has, in our opinion, assumed the main care and support of your beneficiary.

Any benefits we pay under this provision will fully discharge us from all further liability to the extent of the benefits paid.

Claim Review Procedures

If a member or beneficiary does not agree with the denial of his/her claim, we will review our decision in accordance with the following procedure:

1. He/she must file a written appeal and mail it to:

The EPIC Life Insurance Company
Attention: Life & Disability Department
P.O. Box 8430
Madison, Wisconsin 53708-8430

The member or beneficiary must state the specific reasons why he/she does not agree with the denial. We cannot accept telephone requests for review.

2. Upon request, and at no charge, the member or beneficiary may obtain reasonable access to, and copies of, all documents, records and information relevant to his/her claim for benefits.

3. Our review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents and records and other information that either was not submitted previously or was not considered in the initial benefit decision. The review on appeal will be a "fresh" look at the claim without deference to the denial decision. It will be conducted by a person or committee not involved in the denial decision and who is not a subordinate of, or the members of which are not subordinates of EPIC's supervisory or managerial employee involved in the denial decision.

If the member's benefit denial was based in whole or in part on a medical judgement, we will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved with the denial decision, nor be a subordinate of the health care professional who was involved. If we have obtained or will obtain medical or vocational experts in connection with the claim, they will be identified upon the member's or beneficiary's request, regardless of whether we rely on their advice in making any benefit determinations.

4. Within 60 days after we receive the member's or beneficiary's written request for review, we will send the member or beneficiary a written decision which will contain the specific reasons for our decision and identify the specific policy provisions on which the decision is based.

5. In some situations, we may need additional time to make a decision. In that case, before the 60-day period has expired, we will send the member or beneficiary a written notice that more time is necessary. Then we have up to an additional 60 days after the first 60-day period has expired (a total of 120 days from the date we received the member's or beneficiary's request for review) to provide the member or beneficiary with our decision.

Claim Processing Procedure

Following receipt of a correctly filed claim we will advise the member or beneficiary of our decision within 90 days of receiving the claim. A correctly filed claim includes: (1) notarized copy of the death certificate; and (2) completed claim form. Under certain circumstances we may need additional information such as accident or injury related - copies of police report, autopsy report, toxicology report, newspaper article(s) or obituary. We determine that the 90-day period begins the date we are in receipt of all completed statements. Any benefits paid under the policy shall fully discharge us from all further liability, to the extent of benefits paid. If benefits are payable under the policy, payment of such benefits shall be made directly to the member or beneficiary.

In the event of an incomplete claim or circumstances beyond our control, we will advise the member or beneficiary that a 90-day extension is necessary. An incomplete claim is a correctly filed claim that requires additional information such as additional clinical documentation. In the event an extension is required, we will notify the member or beneficiary in writing of the reasons for the extension.

If the claim is denied, the member or beneficiary will receive a written notice from us with: (1) the specific reasons for the denial; (2) the specific references to the policy provisions on which the denial is based; (3) a description of additional material or information which may be necessary for the member or beneficiary to perfect his/her claim and an explanation of why such material or information is necessary; and (4) an explanation of how the member or beneficiary may have the claim reviewed by us if he/she does not agree with the denial or partial denial.

Entire Contract

The entire contract between the policyholder and EPIC is made up of the policy, including the policyholder's group application, the policyholder's supplemental applications, if any, the certificate, Schedule of Benefits, all endorsements, if any, your application, and your supplemental applications, if any.

Waiver and Change

Only the president of EPIC can execute a waiver or make a change to the policy. No agent, broker or other person may waive or change any term, condition, exclusion, limitation, or other provision of the policy in any way or extend the time for any premium payment. At our option, EPIC may unilaterally change any term, condition, exclusion, limitation or other provision of the policy if we send written notice to the policyholder at least 30 days in advance of that change. When the change reduces coverage provided under the policy, we must send written notice of the change to the policyholder at least 60 days before any such change takes effect. Any change to the policy shall be made by endorsement which is signed by the president of EPIC. Each endorsement shall be binding on the policyholder, each of its members, and EPIC. No error by EPIC, the policyholder, or any member shall invalidate coverage otherwise validly in force, continue or reissue coverage validly terminated, or cause coverage to be issued which otherwise would not be issued by EPIC. Upon our discovery of any error, an equitable adjustment of coverage, payment of benefits, and/or premium shall be made by EPIC at its sole option.

Limitation on Lawsuits and Legal Proceedings

No member shall bring any legal action against us regarding payment of benefits, claims submitted, or any other matter concerning his/her coverage under the policy until the earlier of: (1) 60 days after we've received or waived proof of loss described in section “Payment of Claims” for which that legal action is brought; or (2) the date we deny payment of benefits for the claim for which that legal action is brought. Legal action can be brought earlier by that member only if waiting will result in prejudice against that member. However, the mere fact that a member has to wait until the earlier of the above two dates is not considered prejudicial.

Assignment

You may assign any right or interest you have under the policy. Such rights or interests include, but are not limited to, a change of beneficiary or mode of payment in accordance with the policy.

Relative rights of assignee and beneficiary, the rights of a beneficiary under a life insurance policy are subordinate to those of an assignee, unless the beneficiary was effectively designated as an irrevocable beneficiary prior to the assignment.

We will not be charged with notice of any assignment until such assignment is actually received by us and filed at our office. We shall assume no responsibility for the validity or effect of any assignment.

Governing Law, Jurisdiction and Limited Waiver of Sovereign Immunity

1. The policy is made in the State of Wisconsin and shall be governed by, construed and enforced in accordance with the internal laws and administrative rules of the State of Wisconsin, including, but not limited to, all administrative rules issued by the Wisconsin Commissioner of Insurance which apply to the policy, without regard to conflict of law purposes. In this regard, the parties agree that EPIC shall comply with the applicable laws and rules of the State of Wisconsin with respect to the issuance and administration of the policy, including, but not limited to, grievance/appeal rights of persons covered under the policy under the applicable laws and administrative rules of the State of Wisconsin.

2. The policyholder hereby submits, and shall be subject to, the exclusive jurisdiction and venue of the United States District Court for the Eastern District of Wisconsin, and hereby consents to the personal jurisdiction of that court. However, notwithstanding the foregoing, if by application of federal law the United States District Court for the Eastern District of Wisconsin does not have, and cannot obtain, jurisdiction of any dispute between the policyholder and EPIC, then for that dispute the policyholder hereby submits, and shall be subject to, the exclusive jurisdiction and venue of Brown County Circuit Court, Wisconsin, and hereby consents to the personal jurisdiction of that court for that dispute. The policyholder's waiver, submission, and consent includes, but is not limited to, the right to sue and be sued as well as its agreement to have any and all remedies and judgments enforced in such court of law.

3. On behalf of itself and all tribal members, including, but not limited to, persons seeking to become covered persons under the policy, the policyholder hereby expressly and unequivocally waives any requirement of exhaustion of tribal remedies and grants a limited waiver of its sovereign immunity from suit and other legal actions and proceedings for any and all claims, disputes or other matters arising under, in connection with, or related to the policy. The limited waiver of immunity granted herein by the policyholder shall pertain to disputes between EPIC, any affiliate of EPIC, or its parent company, Wisconsin Physicians Service Insurance Corporation, and the policyholder, or any tribal entity of the policyholder, arising under or pertaining to this policy. In addition, the parties understand and agree that any monetary judgment issued by a court of competent jurisdiction against the policyholder pursuant to this limited waiver of sovereign immunity shall be expressly limited to an amount not to exceed Five Million Dollars ($5,000,000.00). The policyholder agrees to take all necessary steps to effectuate this limited waiver of immunity as an express condition precedent to the operation of this policy.

Conformity with Laws of the State

On the effective date of the policy, any term, condition, or provision conflicting with the laws of the state applying to the policy automatically conforms with the minimum requirements of such laws.

General Right of Recovery

If we pay any monies or benefits that are not due or payable under the policy, including, but not limited to, benefits paid in error by us, we have the right to be repaid to the full extent of such overpayment. We shall be

repaid to the full extent of such overpayment. We can recover such excess payments from any person, organization or institution to, for, or with respect to whom such monies were paid by us, including any member. If we cannot recover such excess payments from any other source, we can recover them from you or any of your dependents. When we request that you pay us an amount of the excess payments, you agree to pay us such amount immediately upon our notification to you. We may, at our option, reduce any future payments for which we are liable under the policy by the amount of the excess payments, in order to recover such payments. We will reduce such benefits otherwise payable until the excess payments are recovered by us. Our rights of recovery under this subsection are in addition to any rights we have under common law with respect to such overpayment.

Policyholder as Members' Representative

For any and all purposes regarding this policy, including each member's coverage provided under this policy, the policyholder is not the agent nor representative of EPIC. The policyholder represents only itself and its members insured under this policy. The policyholder, its members, agents and representatives do not represent EPIC, our agents and representatives. The policyholder's agents and representatives are not our agents or representatives and do not represent EPIC, our agents and representatives. EPIC, our agents and representatives are not liable or responsible in any way whatsoever for any act, omission or statement by the policyholder, its members, employees, agents and representatives. In addition, EPIC, our agents and representatives are not agents or representatives of the policyholder, any member insured under the policy or any other person.

Conversion Privilege

If your term life coverage ends or the amount is reduced because your membership in a class ends, you may apply for an individual conversion policy of whole life insurance (called a conversion policy) without giving information about your health. Issuance of a conversion policy is subject to the following conditions:

1. You may apply for the whole life conversion policy that we then make available to such a member who is converting his/her coverage under the policy prepared using sex-blended factors.

2. The face amount of your converted whole life insurance policy may not exceed the amount of your terminated term life coverage under the policy.

3. The premium for your conversion policy will be at our current applicable rate for that policy according to: (1) your class of risk; and (2) your age on the date the policy becomes effective.

4. You must submit written application and your first conversion premium to us within 31 days after your term life coverage ends under the policy.

If your term life coverage ends because of termination of the policy or termination of a class and you have been insured under the policy for the three years immediately prior to your coverage’s termination date, you may apply within 31 days for a conversion policy. Issuance of the conversion policy is subject to conditions 1., 3., and 4., above. The face amount of your converted whole life insurance policy may not exceed the amount of your terminated term life coverage under the policy less any amount for which you become eligible to purchase under any other group term life insurance policy within 31 days.

If you die within the 31-day period after your term life coverage ends, under the policy, we will pay a death benefit equal to the amount of term life coverage you were entitled to convert under the policy.

If we issue a conversion policy and you again become eligible and apply for term life coverage under the policy, your new term life coverage will become effective under the policy only if: (a) you terminate your conversion policy immediately; or (b) you submit, at your own expense, evidence of insurability satisfactory to us.