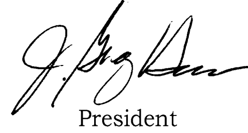
GROUP INSURANCE CERTIFICATE

STANDARD INSURANCE COMPANY certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy. Possession of this Certificate does not necessarily mean you are insured.



President

Printed 1/2008

GROUP POLICY NUMBER	608088-A
NAME OF POLICYHOLDER	State of Montana
TYPE OF COVERAGE	ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
GROUP POLICY EFFECTIVE DATE	September 1, 1990
GROUP POLICY DELIVERED IN	Montana and governed by the laws of that state.

IMPORTANT: PLEASE READ THIS

You are insured only if you meet the requirements in Part 2. BECOMING INSURED. You will remain insured only until your insurance ends, as explained in Part 3. WHEN INSURANCE ENDS.

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, Standard will provide the Policyholder with a notice for you.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate has a Table of Contents to help you find specific provisions. **Defined terms are printed in all capital letters.**

GAC 983

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OUTLINE OF YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

THIS OUTLINE IS INTENDED FOR USE WITH THIS CERTIFICATE AND CANNOT BE USED SEPARATELY AS A DESCRIPTION OF YOUR COVERAGE. OTHER PROVISIONS ARE FOUND IN THIS CERTIFICATE. PLEASE READ THIS CERTIFICATE CAREFULLY.

TYPE OF INSURANCE - ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE provides benefits for dismemberment or death resulting from ACCIDENTAL BODILY INJURIES. Benefits are payable to you, your BENEFICIARY, or your insured DEPENDENTS. See Part 8.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS - The Maximum Amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE is the amount you select from the table shown in Part 7.C. If you elect to insure your eligible DEPENDENTS, the Maximum Amount of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE for each of your eligible DEPENDENTS is a percentage of the Maximum Amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

EXCLUSIONS - No benefit will be paid if either the ACCIDENTAL BODILY INJURIES or the loss is caused or contributed to by any of the causes listed in Part 7.B. The accident must occur while you are insured under the GROUP POLICY, and the loss must occur within 365 days after the accident.

BECOMING INSURED - Part 2 explains when you become insured and Part 3 explains when your eligible DEPENDENTS become insured. Part 4 explains when your INSURANCE ends and Part 5 explains when INSURANCE on your insured DEPENDENTS ends.

CONTRIBUTIONS - The POLICYHOLDER determines the amount of your contribution toward the cost of your INSURANCE.

LIOUT06

Part 1. GENERAL DEFINITIONS

STANDARD means Standard Insurance Company, Portland, Oregon.

EMPLOYER means State of Montana and each subsidiary or affiliate approved in writing by STANDARD.

GROUP POLICY means STANDARD'S group policy number 608088-B issued to the POLICYHOLDER.

INSURANCE means your insurance under the GROUP POLICY.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE means your accidental death and dismemberment insurance under the GROUP POLICY.

SICKNESS means your sickness, illness, or disease.

PREGNANCY means your pregnancy, childbirth, or related medical conditions.

ACCIDENTAL BODILY INJURY means an injury to your body caused by an accident.

CA101A

Part 2. BECOMING INSURED AS A MEMBER

To become insured as a MEMBER you must meet each of the following requirements:

1. You must be a MEMBER.
2. You must be eligible for INSURANCE.
3. You must enroll for INSURANCE.

CA201A9

A. DEFINITION OF MEMBER

You must be a MEMBER. You are a MEMBER if you are an employee of a participating department or agency of the State of Montana and are in one of the following classifications:

1. A permanent full-time employee scheduled to work more than six months in any twelve month period.
2. A permanent part-time or job-share employee who is regularly scheduled to work 20 hours or more per week, and more than six months in any twelve month period.
3. A seasonal employee who is regularly scheduled to work 20 hours or more per week for six months or more a year, or who works 20 hours or more a week for a continuous period of time of more than six months a year although not regularly scheduled to do so.
4. An Elected Official.
5. An Officer or permanent employee of the legislative branch.
6. A Judge or permanent employee of the judicial branch.
7. A temporary employee who is: (a) regularly scheduled to work 20 hours or more per week for more than six months within a year; or (b) works for 20 hours or more per week for a continuous period of more than six months although not regularly scheduled to do so; or (c) covered under a labor union contract which provides for eligibility.
8. A Member of the legislature.

C02A1N

B. ELIGIBILITY FOR INSURANCE

You must be eligible for INSURANCE. You will become eligible for INSURANCE on the later of (A) September 1, 1990, and (B) the date determined as follows:

Elected Officials - on the date you take the oath of office, but not before the date your term begins.

All other MEMBERS - on the first day you are on pay status.

C02B1M

C. ENROLLMENT FOR INSURANCE

You must sign a completed enrollment card and agree to make any required contribution to the POLICYHOLDER.

D. EFFECTIVE DATE OF INSURANCE

Your INSURANCE will become effective on the first day of the calendar month following the month of enrollment for which a full premium payment is made.

CA2C1A9

Part 3. BECOMING INSURED AS A DEPENDENT OF A MEMBER

For you to become insured as a DEPENDENT of a MEMBER, each of the following requirements must be met:

1. You must be a DEPENDENT of a MEMBER.
2. You must be eligible for INSURANCE.
3. The MEMBER must enroll for INSURANCE on the MEMBER'S DEPENDENTS.

CA301A9

A. DEFINITION OF DEPENDENT

You must be a DEPENDENT of a MEMBER. DEPENDENT means a person who is:

SPOUSE DEPENDENT: The MEMBER'S spouse, including a declared common law spouse.

2. CHILD DEPENDENT*: The MEMBER'S unmarried child from birth through the date the child becomes 23 years of age. The MEMBER'S stepchild, adopted child or a child for whom the MEMBER has court ordered custody or legal guardianship, pursuant to the Internal Revenue Code definition of dependent, is considered to be the MEMBER'S child.

*NOTE: An insured CHILD DEPENDENT who ceases to be a CHILD DEPENDENT may qualify for continued INSURANCE as a HANDICAPPED CHILD. See CONTINUED COVERAGE FOR A HANDICAPPED CHILD in Part 5.

CA3A1E9

B. ELIGIBILITY FOR INSURANCE

You are eligible for INSURANCE if you are a DEPENDENT of a MEMBER who is eligible for INSURANCE, except as follows:

1. You are not eligible for INSURANCE if you are a full-time member of the armed forces of any country.
2. You are not eligible for INSURANCE unless the MEMBER becomes insured.

CA3B1A

C. ENROLLMENT FOR INSURANCE

The MEMBER must sign a completed enrollment card and agree to make the required contributions to the EMPLOYER.

D. EFFECTIVE DATE OF INSURANCE

If you are an eligible DEPENDENT, your INSURANCE will become effective on the first day of the calendar month following the month of enrollment for which a full premium payment is made.

While the MEMBER'S INSURANCE on the MEMBER'S eligible DEPENDENTS is in effect, any new eligible DEPENDENT will automatically become insured on the date that person becomes an eligible DEPENDENT.

NOTE: INSURANCE on the DEPENDENTS of a MEMBER covers all of the MEMBER'S eligible DEPENDENTS.

CA3C1A9

Part 4. WHEN A MEMBER'S INSURANCE ENDS

If you are an insured MEMBER, your INSURANCE under the GROUP POLICY will end automatically on the earliest of the following dates:

1. The last day of the last period for which you made the required premium contribution as a MEMBER as defined in Part 2.A., except as provided in the Self Pay Provision below.
2. The date you become a full-time member of the armed forces of any country.
3. The date the GROUP POLICY terminates.

Your INSURANCE may be continued, upon payment of premium, during a leave of absence if continuation of your INSURANCE under the GROUP POLICY is required by the state-mandated family or medical leave act or law.

SELF PAY PROVISION

You may continue your INSURANCE during the following periods by paying the entire cost of your INSURANCE to the EMPLOYER on or before each premium due date. You must elect to continue your INSURANCE on or before the date your INSURANCE would have otherwise ended and you may not become insured again after your INSURANCE ends unless you return to ACTIVE WORK. Your INSURANCE will end on the date determined from 1., 2. and 3. above.

1. For up to 12 months while you are on approved leave without pay status.
2. For up to 12 months while you are receiving Worker's Compensation benefits for any SICKNESS or ACCIDENTAL BODILY INJURY sustained during state employment.

CA401B9

Part 5. WHEN A DEPENDENT'S INSURANCE ENDS

If you are an insured DEPENDENT, your INSURANCE under the GROUP POLICY will end automatically on the earliest of the following dates:

a. The last day of the last period for which a premium payment has been made as of the date you cease to be a DEPENDENT as defined in Part 3.

b. The date you become a full-time member of the armed forces of any country.

c. The date the GROUP POLICY terminates.

d. On the last day of the last period for which the MEMBER made the required premium contribution for your INSURANCE.

e. The date the MEMBER'S INSURANCE ends for any reason.

CONTINUED COVERAGE FOR A HANDICAPPED CHILD:

Your INSURANCE will not end solely because you cease to be a CHILD DEPENDENT if you or your parent who is the insured MEMBER provide STANDARD with satisfactory written proof that you qualify as a HANDICAPPED CHILD. Such proof must be furnished to STANDARD on STANDARD'S forms within 31 days after the date your INSURANCE would otherwise end because you ceased to be a CHILD DEPENDENT, and thereafter as required by STANDARD, but not more than once a year. STANDARD has the right, at its expense, to have you examined at reasonable intervals while you are claiming continued coverage under this provision.

HANDICAPPED CHILD means the unmarried child of an insured MEMBER who, on and after the date the child ceased to be a CHILD DEPENDENT, is both:

1. Continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to the date the child ceased to be a CHILD DEPENDENT; and
2. Continuously chiefly dependent upon the insured MEMBER for support and maintenance or institutionalized because of mental retardation or physical handicap.

If you are a HANDICAPPED CHILD whose INSURANCE is continued under this provision, your INSURANCE will end automatically on the earliest of the following dates:

1. The last day of the calendar month in which you cease to be a HANDICAPPED CHILD as defined above.
2. 90 days after the date STANDARD mails you a request for proof that you continue to qualify as a HANDICAPPED CHILD, unless you provide STANDARD with the required proof within that 90 day period.
3. The date your coverage would end under this Part 5 for any reason other than your ceasing to be a CHILD DEPENDENT.

CA501A9

Part 6. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

A MEMBER and the DEPENDENTS of the MEMBER may become insured again under the GROUP POLICY after INSURANCE ends on the same basis as a new MEMBER or DEPENDENT of a MEMBER, as provided in Parts 2 and 3. However, the following will apply:

1. If INSURANCE ends because a person insured as a MEMBER ceases to be a MEMBER, that person will be immediately eligible for INSURANCE if the person insured as a MEMBER becomes a MEMBER again within 90 days after the INSURANCE ends.
2. If INSURANCE ends because a person insured as a MEMBER is on a federal or state mandated family or medical leave of absence, and that person becomes a MEMBER again immediately following the period allowed, that person's INSURANCE will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

INSURANCE which becomes effective again will not be retroactive to the date the INSURANCE ended.

CA601A

Part 7. ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. INSURING CLAUSE

Subject to all the terms of the GROUP POLICY, STANDARD will pay the amount shown in the Schedule of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE upon receipt of satisfactory written proof that you have sustained any of the losses shown in that Schedule, provided that all of the following conditions are met:

1. The loss must be caused solely and directly by ACCIDENTAL BODILY INJURIES, and the loss must occur independently of all other causes;
2. The accident must occur while you are insured under the GROUP POLICY; and
3. The loss must occur within 365 days after the date of the accident.

CA7A1A

B. EXCLUSIONS

Even though a loss results from ACCIDENTAL BODILY INJURIES, no payment will be made if either the ACCIDENTAL BODILY INJURIES or the loss is caused or contributed to by any of the following:

1. Insurrection, war or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict with organized forces of a military nature.
2. Suicide or any other intentionally self-inflicted injury, while sane or insane.
3. Committing or attempting to commit an assault or a felony or your active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot in the performance of your official duties.
4. The voluntary use or consumption of any poison, chemical compound or drug (including but not limited to prescribed medications), unless used or consumed in accordance with the directions of a physician.
5. Any SICKNESS or PREGNANCY existing at the time of the accident.

6. Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction).

7. Medical or surgical treatment for any of 1 through 6 above.

8. Travel or flight in or descent from any kind of aircraft as a pilot or crew member. However, this exclusion does not apply to travel or flight in or descent from POLICYHOLDER owned, leased or operated aircraft while you are on state business.

CA7B1D9

C. SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The MEMBER selects MAXIMUM AMOUNTS of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE in increments of $25,000, from $25,000 to $500,000, but not more than 10 times the MEMBER'S annual rate of earnings from the EMPLOYER.

If the MEMBER elects to insure the eligible DEPENDENTS of the MEMBER, the MAXIMUM AMOUNT of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE for the DEPENDENT(S) of the MEMBER is determined as follows:

1. Insured spouse only: The MAXIMUM AMOUNT for the spouse is 50% of the MAXIMUM AMOUNT for the MEMBER.

2. Insured child(ren) only: The MAXIMUM AMOUNT for each child is 10% of the MAXIMUM AMOUNT for the MEMBER.

3. Insured spouse and child(ren): The MAXIMUM AMOUNT for the spouse is 40% of the MAXIMUM AMOUNT for the MEMBER and the MAXIMUM AMOUNT for each child is 10% of the MAXIMUM AMOUNT for the MEMBER.

MAXIMUM AMOUNT means the amount of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

EFFECTIVE DATE OF CHANGES IN AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

The MEMBER may change the MAXIMUM AMOUNT of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE by signing a new completed enrollment card.

Changes in the MAXIMUM AMOUNT of the MEMBER'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE which are selected during the EMPLOYER'S annual change period will become effective on the following September 1 provided the required premium payment is made.

Changes in the MAXIMUM AMOUNT of the MEMBER'S ACCIDENTAL DEATH AND DISMEMBERMENT selected following a Change in Family Status under Internal Revenue Code Section 125 become effective on the first day of the calendar month following the date of the Family Status Change, provided the required premium payment is made.

A change in the MAXIMUM AMOUNT of INSURANCE for the MEMBER will also change the MAXIMUM AMOUNT of INSURANCE for insured DEPENDENTS, if any.

Changes in the MAXIMUM AMOUNT of INSURANCE for insured DEPENDENTS because of any change in the DEPENDENTS insured will become effective on the date of such change.

NOTE: The benefit payable for an Accidental Loss is determined by the MAXIMUM AMOUNT of INSURANCE in effect on the date of the accident.

Benefit for Accidental Loss of

Life ....MAXIMUM AMOUNT

Both Hands or Feet or

Sight of Both Eyes..............................MAXIMUM AMOUNT

One Hand and One Foot ....MAXIMUM AMOUNT

Either Hand or Foot and

Sight of One Eye................................MAXIMUM AMOUNT

Either Hand or Foot .... One-Half MAXIMUM AMOUNT

Sight of One Eye................. One-Half MAXIMUM AMOUNT

Loss of a hand or a foot means permanent severance of the hand or foot from the body at or above the wrist or ankle joint; loss of sight of an eye means entire and irrecoverable loss of sight.

No more than the MAXIMUM AMOUNT of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE will be paid for all losses suffered by one insured person as a result of one accident.

CA7C1C9

Part 8. PAYMENT OF CLAIMS

A. PAYMENT OF BENEFITS

Benefits for Accidental Loss will be paid as follows:

1. All death benefits payable because of the accidental death of the insured MEMBER will be paid in accordance with the BENEFICIARY provisions in G of this Part 8.
2. All death benefits payable because of the accidental death of an insured DEPENDENT will be paid to the MEMBER. If the MEMBER is not living, the death benefit will be paid in equal shares to the first surviving class of the following classes:
   a. The children of the insured DEPENDENT who died.
   b. The parents of the insured DEPENDENT who died.

   If none of them survives the insured DEPENDENT, the death benefits will be paid to the estate of the insured DEPENDENT.
3. All accidental dismemberment benefits will be paid in a lump sum to the insured person who suffered the loss for which the benefits are payable.

   Any accidental dismemberment benefits remaining unpaid at the death of the person who suffered the loss will be paid in accordance with the provisions for payment of a death benefit.

B. TIME LIMITS FOR FILING A CLAIM

All benefits must be claimed within 90 days after the date of loss or as soon thereafter as reasonably possible and, in any case, within one year after the end of that 90 day period. Claims not filed within these time limits will be denied and no benefit will be paid. These time limits will not apply during any period when the claimant lacked the legal capacity to file a claim.

C. FILING A CLAIM

All claims for benefits should be submitted on STANDARD'S forms. You should obtain claim forms from the POLICYHOLDER or the Plan Administrator.

You may also request claim forms from STANDARD. If STANDARD fails to provide you with claim forms within 15 days of your request you may submit your claim in a letter stating the occurrence, character and extent of the event for which the claim is made.

D. PROOF OF LOSS

Satisfactory written proof of loss in connection with a claim for benefits must be provided to STANDARD at the expense of the person claiming the benefits.

No benefits will be paid until STANDARD has received satisfactory written proof of loss in connection with the claim for benefits.

E. INVESTIGATION OF YOUR CLAIM

STANDARD has the right to conduct an independent investigation of any claim for benefits under the GROUP POLICY. No benefits will be paid until STANDARD has had a reasonable time to conduct an investigation. STANDARD will provide written notice to the person claiming the benefits and the POLICYHOLDER of any independent investigation within 30 days after your claim is received.

F. INDEPENDENT EXAMINATION AND AUTOPSY

STANDARD has the right to have the person who suffered the Accidental Loss examined at STANDARD'S expense in connection with a claim for Accidental Dismemberment benefits. Any such examination will be conducted by one or more physicians of STANDARD'S choice.

STANDARD has the right to have an autopsy performed at STANDARD'S expense, except where prohibited by law.

G. BENEFICIARY PROVISIONS FOR INSURED MEMBERS

The following BENEFICIARY provisions only apply to you if you are insured as a MEMBER. An insured DEPENDENT may not designate a BENEFICIARY.

1. NAMING A BENEFICIARY

BENEFICIARY or BENEFICIARIES mean the person or persons you name to receive the benefits under the GROUP POLICY if you die. You may name or change death BENEFICIARIES at any time. The consent of a named BENEFICIARY is not needed to change BENEFICIARIES.

BENEFICIARY DESIGNATION means the written instrument in which you name or change your BENEFICIARY. Writing includes a form signed by you or a verification from the Policyholder or Employer of an electronic or telephonic designation made by you. Your written BENEFICIARY DESIGNATION must be dated and delivered to the POLICYHOLDER during your lifetime. Your BENEFICIARY DESIGNATION will take effect on the date it is delivered to the POLICYHOLDER. The BENEFICIARY DESIGNATION must relate to the INSURANCE provided under the GROUP POLICY. If the GROUP POLICY replaces all or a part of the insurance provided by an earlier policy, a written BENEFICIARY DESIGNATION signed and dated by you under the earlier policy will be accepted as your BENEFICIARY DESIGNATION under the GROUP POLICY.

2. PAYMENT TO YOUR BENEFICIARY

Death benefits will be paid to your surviving BENEFICIARY or BENEFICIARIES in the highest class, with the classes ranking in the following order: primary, followed by first contingent, second contingent, etc. Two or more surviving BENEFICIARIES in the same class will share equally, unless you specify their respective shares.

Payment of death benefits to a BENEFICIARY in the amount of $10,000 or more will be made by deposit into a Standard Secure Access account. Standard Secure Access is an interest- bearing checking account in the name of the BENEFICIARY, as owner. The

account is subject to the terms and conditions of a Confirmation Certificate which will be given to the BENEFICIARY. The funds are fully guaranteed by STANDARD.

If a BENEFICIARY chooses not to participate in the andard Secure Access account described above, the amount payable to a BENEFICIARY may be paid in installments over a period of years upon mutual agreement between STANDARD and the BENEFICIARY. To the extent permitted by law, the amount payable to a BENEFICIARY will not be subject to any legal process against the BENEFICIARY or to the claims of any creditor or creditor's representative.

3. BENEFICIARY MUST SURVIVE YOU

If a BENEFICIARY dies on the date of your death, or within 15 days after the date of your death, death benefits will be paid as if that BENEFICIARY had died before you, unless satisfactory proof of loss with respect to your death is delivered to STANDARD before the date of the BENEFICIARY'S death.

4. NO SURVIVING BENEFICIARY

If you do not name a BENEFICIARY, or if you are not survived by a BENEFICIARY, all death benefits will be paid in equal shares to the first surviving class of the following classes:

a. Your spouse.

b. Your children.

c. Your parents.

If none of them survives you, the benefits will be paid to your estate.

H. RELIANCE BY STANDARD

STANDARD may rely on an affidavit or other written evidence deemed satisfactory to STANDARD to determine the identity or the nonexistence of BENEFICIARIES not identified by name. Any payment made by STANDARD in good faith reliance on such evidence will fully discharge STANDARD to the extent of such payment.

I. NOTICE OF DECISION ON CLAIM

You will receive a written decision on your claim within a reasonable period of time after STANDARD receives your claim.

If STANDARD denies all or any part of your claim, you will receive a written notice of denial containing:

1. The reason for the denial;
2. Reference to the provisions of the GROUP POLICY on which the denial is based;
3. A description of any additional information or documentation you must submit to obtain benefits and an explanation of why such information or documentation is required;
4. Notice of your right to a review of the denial; and
5. A description of the review procedure.

If you do not receive a written decision on your claim within 90 days after your claim is received, you will have an immediate right to request a review under the review procedure, as if your claim had been denied.

J. REVIEW PROCEDURE

You have the right to a review of any denial by STANDARD of all or any part of your claim. To obtain a review, you should send a written request for review to STANDARD within 60 days after you received notice of the denial. No special form is required.

As part of your request for review, you may submit issues and comments in writing and provide additional documentation in support of your claim. You may review and obtain copies of pertinent documents related to your request for review.

STANDARD will review your claim promptly after receiving your request for review. You will receive written notice of STANDARD'S decision within 60 days after your request for review is received, or within 120 days if special circumstances require an extension. The written decision you receive will include the reasons for the decision and reference to the provisions of the GROUP POLICY on which the decision is based.

You may authorize another person to act for you under this review procedure.

CA801A9

Part 9. TIME LIMITS ON LEGAL ACTIONS AND CERTAIN DEFENSES

No action at law or in equity may be brought to recover under the GROUP POLICY until 60 days after written proof of loss has been provided to STANDARD.

Any statement you make to obtain INSURANCE will be a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your INSURANCE unless:

a. Your INSURANCE would not have been approved except for your misrepresentation;

b. Your misrepresentation is contained in a written instrument signed by you; and

c. A copy of the written instrument containing your misrepresentation has been given to you or your BENEFICIARY.

After your INSURANCE has been in effect for two years, no misrepresentation by you, except a fraudulent misrepresentation made with actual intent to deceive, will be used to reduce or deny your claim or to deny the validity of your INSURANCE.

CA901E

Part 10. ASSIGNMENT

The INSURANCE provided and benefits payable are not assignable.

CA100A