ADVANCE
Insurance Company of Kansas
1133 S.W. Topeka Boulevard, Topeka, Kansas 66629-0001 (785) 273-9804

CERTIFIES THAT Group Policy No. 00022172 has been issued on April 1, 2012

TO: (The Policyholder) The Villages
7240 SW 10th St
Topeka, KS 66615

CERTIFICATE OF GROUP INSURANCE

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

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. All provisions, limitations, and exclusions of the group insurance policy apply to the insurance evidenced by this Certificate, even if not mentioned in this Certificate. As a Certificate of Insurance, it is not a contract of insurance, it only summarizes the provisions of the Policy.

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*The coverages specified are included only if the Policy contains the specific sections identified.

SUMMARY OF BENEFITS

ELIGIBILITY

Eligible Persons must be Actively at Work a minimum of 30 hours per week.

SHORT TERM DISABILITY INSURANCE

MAXIMUM WEEKLY AMOUNT OF BENEFIT
$800

MINIMUM WEEKLY AMOUNT OF BENEFIT
10% of the Insured's Weekly STD Benefit

MAXIMUM BENEFIT PERIOD: 26 Weeks

DAY BENEFITS BEGIN: 1st day of Total Disability due to Accidental Injury; and
8th day of Total Disability due to Sickness

Short Term Disability benefits may not exceed 66 2/3% of your Basic Weekly Earnings.

Basic Weekly Earnings means the weekly rate of pay being used to calculate the premium for you on the policyholder's billing at the time of Disability. It does not include commissions, bonuses, overtime pay or any other extra pay.

The Maximum Benefit Period will reduce 50% when you attain age 70 and coverage will cease upon your retirement.

AMOUNT OF INSURANCE

The amount of your insurance is determined from the Summary of Benefits. The initial amount of coverage is the amount that applies to your classification on the date the coverage becomes effective. You may become eligible for increases/decreases in the amount of insurance in accordance with the Summary, provided you are Actively at Work on that day. Any increase/decrease will be effective on the latest of:

1) the first day of the Insurance Month which coincides with or follows the date the Company receives notification of the salary change.
2) the first day of the Insurance Month which coincides with or follows the date you become eligible for the increase/decrease;
3) the day you resume Active Work if not Actively at Work on the day the increase/decrease otherwise would have been effective; or
4) the day any required Evidence of Insurability is approved by the Company.

Insurance benefits based on salary will be determined by the salary information being used to calculate your premium as shown on the Policyholder's billing at the time of Disability.

DEFINITIONS

Accident or Accidental Bodily Injury means an unforeseen, unexpected and unintended event, which is the direct cause, independent of disease or bodily infirmity or any other cause, of an accidental bodily injury sustained by you while your coverage is in force under the Policy.

Actively at Work or Active Work means to be eligible to be insured or for any increase in insurance, you are actively at work; performing all of the normal duties of your job at your usual place of employment and working at least the minimum number of hours each week designated in writing by the Policyholder (or Participating Employer) and agreed to by the Company. If you are absent from work on a day when you would otherwise be eligible to become insured or increase the amount of your insurance, eligibility shall be considered suspended until you return to active work.

Eligibility will not be suspended for time off for vacation, jury duty or funeral leave where you could have been Actively at Work on that day. Eligibility will be suspended for time off due to an Injury or Sickness, a strike, lockout or layoff.

Owners, partners and individual proprietors are subject to, and are required to be working each week, the minimum hourly requirement to be Actively at Work.

Except as otherwise specifically provided by the terms of this policy, you are eligible to continue to be insured only while you continue on Active Work.

Company means Advance Insurance Company of Kansas.

Contributory Insurance means insurance for which an Eligible Person enrolls and agrees to pay a portion of the premium or the entire premium. Contributory Insurance requires at least 75% enrollment of the Eligible Persons. Evidence of Insurability satisfactory to the Company is required if Enrollment is not received by the Company within 63 days of Eligibility.

Eligible Person means an individual who is a resident citizen of the United States or alien legally residing in the United States, who:

1) is employed with the Policyholder or Participating Employer as your main occupation;
2) is working at this occupation at least the minimum number of hours each week as designated in writing by the Policyholder or Participating Employer and agreed to by the Company;
3) is a member of an Eligible Class that is covered by this Policy;
4) has been Actively At Work for at least three out of the four working weeks immediately preceding your eligibility date for coverage; and
5) is not a part-time, temporary, seasonal, leased, contracted or 1099 employee.

Evidence of Insurability means a medical history that is satisfactory to the Company that will include, but is not limited to, your health statement, submitting to a medical examination, if requested, and medical records provided to the Company by your physician, medical practitioner, medical facility or other provider of medical services. Evidence of Insurability must be provided at your expense. We will use the medical history to determine if you are eligible to become insured under the Policy or eligible for any increases in insurance.

Guarantee Issue means the guaranteed coverage you may receive, up to a specified amount, without providing Evidence of Insurability satisfactory to the Company, when your Enrollment is received by the Company within 63 days of Eligibility. After 63 days, you are not eligible for Guarantee Issue if the Insurance is Contributory or Non-Contributory Insurance is rejected in writing.

Hospital means an institution that is a short term, acute, general hospital or intensive care unit that:

1) is a duly licensed public or private institution;
2) has organized departments for medicine and major surgery; and
3) or compensation, is engaged in providing inpatient, diagnostic, therapeutic, and psychiatric services for diagnosis, treatment, and care of sick and injured persons.

Insurance Month means that period of time beginning at 12:00 A.M. on the first day of any calendar month and ending at 11:59 P.M. on the last day of the same calendar month.

Insured or Insured Person means the individual who is eligible for the coverage provided by the Policy, who is enrolled, the required premium is paid, and coverage is in force under this Policy.

DEFINITIONS (continued)

Male Pronoun whenever used includes the female.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations of psychological, behavioral or emotional disorders, but excluding demonstrable, structural brain damage.

Non-Contributory Insurance means insurance for which the Policyholder pays the entire premium. Non-Contributory Insurance requires 100% enrollment of the Eligible Persons except for those who reject the coverage in writing or any as to whom Evidence of Insurability is not satisfactory to the Company. The Policyholder will be billed for premium from the Effective Date of insurance.

Partial Disability or Partially Disabled means you are unable to perform one or more but not all of the material duties of employment or occupation.

Physician means a person who is: 1) a doctor of medicine, osteopathy, psychology, or other healing art recognized by the Company; and 2) licensed to practice in the state or jurisdiction where care is being given; and 3) practicing within the scope of that license.

Physician will not include you or a relative of you.

Policy means this Group Insurance Policy issued by the Company to the Policyholder.

Policyholder means the employer or association as shown on the Cover Page of the Policy.

Regular Care of a Physician means you personally see and are attended by a Physician (who is not the Insured or a relative):

1) with medical training and clinical experience suitable to treat the Insured's disabling condition; and
2) whose treatment is consistent with the diagnosis of the disabling condition; according to guidelines established by medical, research, and rehabilitative organizations; and administered as often as needed to achieve the maximum medical improvement.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for your retirement and which is not funded wholly by your contributions. It does not include: 1) a profit sharing plan; 2) thrift, savings or stock ownership plans; 3) a non-qualified deferred compensation plan; or 4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k), or 403(b) plan.

Sickness means illness, disease, pregnancy, complications of pregnancy, childbirth, or miscarriage. The Sickness must begin while your coverage is in force under the Policy.

Total Disability or Totally Disabled means that you, as a result of Injury or Sickness, are under the Regular Care of a Physician, and are unable to engage in any employment or occupation for which you are, or become, qualified by reason of education, training or experience. The failure to pass a physician examination required to maintain a license to perform the duties of the Insured's occupation does not alone mean that the Insured is disabled. Total Disability must begin while your coverage is in force under the Policy. A person engaged in any gainful employment for wage or profit is not Totally Disabled.

Treatment includes, but is not limited to, medical examinations, tests, attendance or observation, use of drugs, medicines, medical services, supplies or equipment.

Waiting Period means the number of days you must be Actively at Work in an eligible class before becoming eligible for insurance. The Waiting Period is described in the Application for Group Insurance or as designated in writing by the Policyholder (or Participating Employer) and agreed to by the Company.

Voluntary Insurance means insurance for which you enroll and agree to pay a portion of, or the entire premium. Voluntary Insurance enrollment requirements are shown in the proposal of coverage attached to the Policy. Evidence of Insurability satisfactory to the Company, and enrolling during an Annual Enrollment period, is required if Enrollment is not received by the Company within 63 days of Eligibility.

ELIGIBILITY AND EFFECTIVE DATES OF COVERAGE

Eligibility. If you are an Eligible Person, 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 first day of the Insurance Month coinciding with or next following the date you complete the Waiting Period as an Eligible Person.

Enrollment. To enroll in coverage, or reject Non-Contributory Insurance, you must submit the information required:

1) electronically or in writing in a group insurance enrollment form or waiver form which is satisfactory to us;
2) sign and deliver it to the Employer; and
3) it must be received by the Company within 63 days of eligibility.

Evidence of Insurability satisfactory to the Company must be submitted if:

1) the Insurance is Contributory and your enrollment form is received more than 63 days after the day of Eligibility;
2) the Insurance is Non-Contributory and you reject coverage; or
3) you are enrolling in an amount of insurance exceeding the Guarantee Issue, if applicable.

Effective Date. Your insurance is effective on the later of the dates you:

1) become eligible for the coverage;
2) resume Active Work, if not Actively at Work on the day of Eligibility; or
3) receive the Company's approval of your Evidence of Insurability, if required.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of:

1) the day the Policy terminates;
2) the last day of the Insurance Month in which you request termination of coverage;
3) the last day of the Insurance Month for which premium payment is made on your behalf;
4) the day you cease to be in a class of persons that is eligible for coverage under the Policy;
5) the day you cease to be a Full-time Employee Actively at Work including a temporary layoff, leave of absence or a general work stoppage (including a strike or lockout);
6) the day you enter the Armed Forces of any state or country on active duty except for duty of 30 days or less for training in the Reserves or National Guard;
7) the day your Employer ceases to be a Participating Employer;
8) the last day of the month in which your employment with the Policyholder (or Participating Employer, if applicable) terminates; or
9) the last day of the Insurance Month in which a written waiver is received rejecting Non-contributory Insurance.

Termination of coverage under the Policy will not prejudice any claim that is incurred while the Policy is in force.

REFUND OF PREMIUM

If any premium is paid for you beyond the date coverage terminated, the Company will refund the amount paid up to twelve (12) months. Coverage will not extend beyond your termination date, subject to the terms of the preceding paragraphs dealing with the cessation of active work.

CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given within 20 days after the occurrence or commencement of any loss covered by the Policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of you or your beneficiary to the Company at its Home Office or to any authorized agent of the Company with information sufficient to identify you, will be deemed notice to the Company.

Claim Forms. When notice of claim is received, the Company will send forms for filing the required proof to the claimant. If the claimant does not receive these forms within 15 days, the proof of loss requirement may be met by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

Proofs of Loss. Written proof of loss must be furnished to the Company's Home Office in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable. Failure to furnish the proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within the time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time Payment of Claims. Subject to proof of loss, benefits payable for disability will be paid bi-weekly, and any balance remaining unpaid upon the termination of liability will be paid upon receipt of required written proof.

Payment of Claims. Benefits are payable to you, or an eligible survivor at your death, in accordance with the policy and the provisions respecting the payment described herein and effective at the time of payment. If any benefit under this Policy becomes payable, the Company has the right to pay up to $1,000 to any of your relatives by blood or connection by marriage that the Company considers equitably entitled. Any payment made in good faith under this Section will fully discharge the Company to the extent of the payment.

Physical Exams. The Company at its expense may have you examined as often as reasonably necessary while any claim is pending.

Legal Actions. No legal action to recover any benefits may be brought before 60 days after the required written proof of loss has been given. No legal action may be brought more than 5 years after written proof of loss is required to be given.

Appeal Process. If your claim is denied, you or your representative may appeal to us for a full and fair review. You may:

1) request a review upon written application within 180 days of the claim denial;
2) request copies of all documents, records and other information relevant to your claim; and
3) submit written comments, documents, records and other information relating to your claim.

We will make a decision no more than 45 days after we receive your appeal unless we determine special circumstances exist that require an extension of time to process the appeal. If your appeal requires extension, we will make our decision no more than 90 days after we receive your appeal. If we request additional information from you, the time from our request for information until we receive it is not included in the time limit for a decision to be made. The written decision will include specific references to the Policy provisions on which the decision is based.

Interpreting the Policy Terms and Conditions. Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), if applicable, or pursuant to contract if ERISA does not apply, the Company has been delegated the discretionary authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the policy, as well as the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits pursuant to the policy. We have the continuing fiduciary duty to act prudently and in the interest of the Insured, their beneficiaries, and other plan participants and beneficiaries. If an Insured has a claim for benefits that is denied or ignored, in whole or in part, the claimant, or the claimant's representative may file suit in court for a review of eligibility or entitlement to benefits under the policy. This right accrues only upon exhaustion of the appeals procedure provided above. This provision applies whether or not the interpretation of the policy is governed by ERISA.

Right to Recovery. If a payment made by the Company under the Policy exceeds the correct amount due under the Policy, the Company may recover the overpayment from the person, or their estate, or entity to which the benefit was paid.

SHORT TERM DISABILITY BENEFIT

Short Term Disability Benefit. The Company will pay a Weekly Short Term Disability Benefit as shown in the Summary of Benefits if you become Totally Disabled while your coverage for this benefit is in force and you experience a loss of income due to this disability. The Short Term Disability Benefit will be paid for each week the Total Disability continues:

1) beginning on the Day Benefits Begin, as shown in the Summary of Benefits; and
2) ending on the day Total Disability ends, except benefits will not be payable beyond the end of the Maximum Benefit Period shown in the Summary of Benefits.

To begin benefits as stated for an Injury, Total Disability must begin within 90 days of the date of the Accident; otherwise the Total Disability will be considered a Sickness. Proportional benefits will be paid for a partial week of Total Disability.

Calculation of the Benefit. The Weekly Short Term Disability Benefit is calculated using the Basic Weekly Earnings Benefit selected by the Insured as represented by the premium on the Policyholder's billing at the time of Disability. To figure the amount of the Weekly Benefit:

1) multiply your Basic Weekly Earnings by the benefit percentage shown in the Summary of Benefits page; and,
2) take the lesser of:
   a) the amount figured in step (1) above; or
   b) the maximum Weekly Benefit shown in the Summary of Benefits; and then
3) deduct Other Income Benefits from this amount.

This is the total Weekly Short Term Disability Benefit that you may receive. The benefit will never be less than the minimum shown in the Summary of Benefits.

Partial Disability Benefit. The Company will pay a benefit for Partial Disability if:

1) you become Partially Disabled within 30 days after benefits for Total Disability cease;
2) the Partial Disability is due to a Sickness or Injury which is the same as (or related to) the cause of the prior period of Total Disability for which benefits were payable; and
3) you earn less than 80% of Basic Weekly Earnings when Partial Disability employment begins.

Benefits for Partial Disability will end on the earliest of:

1) the date the Maximum Benefit Period ends;
2) the date you cease to be Partially Disabled; or
3) the date your current earnings exceed 85% of Basic Weekly Earnings.

The amount of benefit for Partial Disability equals the lesser of:

1) your Basic Weekly Earnings multiplied by the Benefit Percentage shown in the Summary of Benefits (not to exceed the Maximum Weekly Benefit); or
2) your Basic Weekly Earnings minus earnings received from any form of employment, and any Other Income Benefits, for that period of Total Disability.

The benefit will never be less than the minimum shown in the Summary of Benefits.

Succeeding Periods of Disability. Unless you return to Active Work for at least four consecutive weeks as a full time employee, two or more periods of Total Disability will be treated as one period of Total Disability.

SHORT TERM DISABILITY BENEFITS (continued)

Reduction for Other Benefits. Any benefit payable for loss of income provided to you as a result of the period of Disability for which benefits are being claimed under this plan will be reduced by the amount of any payments you and your family, or a third party on your behalf, receives or are entitled to receive from any:

1) law or governmental program that provides disability or unemployment benefits as a result of your job with the Employer;
2) plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer or as a result of membership in or association with any group, association, union or other organization;
3) any other disability policy sponsored by the Employer;
4) other disability benefits to the extent that such benefits are payable under an automobile policy;
5) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for the Insured's loss of earnings;
6) disability benefit under the Employer's Retirement Plan;
7) disability and retirement benefits under:
   a) the United States Social Security Act, or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan, or any provincial pension or disability plan; or
   d) similar plan or act that the Insured, the Insured's spouse and children, is eligible to receive because of the Insured's Disability
8) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) the Insured was receiving it prior to becoming Disabled; or
   b) the Insured immediately transfers the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under this plan; and
2) is a general increase which applies to all persons who are entitled to such benefits.

While a Short Term Disability Benefit is payable under the Group Policy, benefits will not be reduced to an amount less than the Minimum Weekly Short Term Disability Benefit shown on the Schedule of Insurance.

Exclusions. Short Term Disability Benefits will not be payable for any period of Total Disability:

1) prior to the Day Benefits Begin;
2) during which you receive payment under salary continuance, which will include but is not limited to vacation, severance pay or a sick leave program; or, retirement plan sponsored by his employer;
3) that is the result of a Sickness or Injury covered by any Workers' Compensation law, occupational disease law or similar law;
4) that is the result of, or due to, a Sickness or Injury arising out of, or in the course of, any employment for wage or profit;
5) during which the Insured is not under the Regular Care of a Physician;
6) that is the result of an intentional act; active participation in a riot; or commission of a crime;
7) due to war, declared or undeclared; or any act of war.

GENERAL PURPOSES AND LIMITATIONS OF THE
KANSAS LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION
K.S.A. 40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance
  $300,000 in death benefits
  $100,000 in cash surrender or withdrawal values
- Health Insurance
  $500,000 in hospital, medical and surgical insurance benefits
  $300,000 in disability insurance benefits
  $300,000 in long-term care benefits
  $100,000 in other types of health insurance benefits
- Annuities
  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.