American National Property And Casualty Company
1949 East Sunshine St.
Springfield, MO 65899-0001
"A Stock Insurance Company"

Administrative Office:
Customer Care Center
PO Box 740237
Atlanta, GA 30374-0237
1-866-453-5616

INVOLUNTARY UNEMPLOYMENT INSURANCE POLICY SCHEDULE OF INSURANCE		
Policy Number:		
Covered Person's Name:		
Covered Person's Address:		
Effective Date:	**Expiration Date:** Monthly; subject to the terms and conditions stated herein.	
12:01 a.m. local standard time at the address of the address of the Covered Person.		
Monthly Premium:		Due on or before the premium due date each month in order to continue coverage.
Premium Due Date:		

COVERAGE	**MAXIMUM BENEFIT AMOUNT**	**MAXIMUM BENEFIT PERIOD**

BENEFIT OPTIONS	**BENEFIT OPTIONS DAYS / MONTHS**

Endorsement(s):	Endorsements listed below attach to and form a part of the Involuntary Unemployment Insurance Policy.

RIGHT TO EXAMINE

If **You**, the **Covered Person**, are not satisfied with this insurance after **You** receive it, **You** may cancel this Involuntary Unemployment Insurance Policy (hereinafter referred to as "**Policy**") within thirty (30) days after the **Effective Date,** which is shown in the Policy Schedule of Insurance (hereinafter referred to as "**Schedule**") and receive a full refund of any premium paid.

To cancel this **Policy,** contact **Us** at **Our Administrative Office** at 1-866-453-5616 between 9:00 a.m. and 6:00 p.m. Eastern Time, Monday through Friday or by mail at PO Box 740237, Atlanta, GA 30374-0237.

Eligible **Covered Persons** shall be between the ages 18 through 60. All coverages will terminate automatically when a **Covered Person** attains age 65.

Benefit amounts shown in the **Schedule** are payable directly to **You**. **We** have no contractual obligation to make payments to other payees on **Your** behalf. **You** will not be eligible for benefits until the **Vesting Period** and **Waiting Period** has been satisfied.

INVOLUNTARY UNEMPLOYMENT INSURANCE POLICY

This Involuntary Unemployment Insurance Policy, together with the Application for Insurance, the Policy Schedule of Insurance, any insurance coverage riders, and any endorsements make up the entire contract of insurance. **YOU SHOULD CAREFULLY READ THE ENTIRE CONTRACT FOR ADDITIONAL TERMS AND CONDITIONS THAT MAY PREVENT YOU FROM RECEIVING BENEFITS.**

Your coverage and the **Effective Date Your** coverage begins are shown in the **Schedule**.

American National Property And Casualty Company (herein called "**We**," "**Us**," or "**Our**") has issued the **Policy** to the **Covered Person** shown in the **Schedule**.

We agree to pay the benefits described subject to all terms and conditions of this **Policy**.

You may qualify for only one (1) Involuntary Unemployment **Policy** with **Us**. If **You** are insured under more than one (1) **Policy**, **We** will consider **You** to be insured under the **Policy** providing the greatest amount of coverage. Upon discovery of the duplication, **We** will cancel the appropriate **Policy** and will refund any premiums paid for the coverage it provided.

The records maintained by **Us** shall determine the insurance provided under the **Policy** for any **Covered Person.**

INVOLUNTARY UNEMPLOYMENT INSURANCE POLICY
CONTENTS

DEFINITIONS

When used in this **Policy**, the following words and phrases have the meaning given.

ADMINISTRATIVE OFFICE means Customer Care Center, PO Box 740237, Atlanta, GA 30374-0237, 1-866-453-5616.

BENEFIT PERIOD means the period of consecutive days of **Loss** for which a benefit is payable.

The **Benefit Period** will begin on the first day of the **Loss** after the **Waiting Period** has been satisfied and will end on the first of the following:

(1) the date **You** are no longer incurring the **Loss**; or
(2) when the Maximum Benefit Period shown in the **Schedule** has been reached.

The same continuous **Loss** is eligible for only one (1) **Benefit Period**.

COVERED PERSON means the **Covered Person** named in the **Schedule**.

EFFECTIVE DATE means the date coverage becomes effective as shown in the **Schedule**.

EMPLOYMENT means working in a non-seasonal, full-time (at least thirty (30) hours per week) occupation for salary or wages during the ninety (90) day period immediately preceding the date of **Loss**.

INVOLUNTARY UNEMPLOYMENT means the total and continuous **Loss** of **Your** non-seasonal, full-time **Employment** resulting from one or more of the following:

(1) an individual layoff not due to willful or criminal misconduct: means an ending of employment at the will of the employer;
(2) a mass layoff: means an ending of employment at the will of the employer;
(3) a general strike: means a strike against all the employers in an industry or a territory; a simultaneous cessation or quitting of work by a body of workers acting in combination for the purpose of obtaining for themselves more desirable terms of employment;
(4) a unionized labor dispute: means a trade or labor union, through the coalition of its members, has authorized a strike to obtain higher wages, shorter hours of employment, better working conditions, or some other concession from the employer by the employees stopping work at a predetermined time, and it involves a combination of persons and not a single individual;
(5) a lockout: means an employer's discharge of his employees, because of a labor dispute or because of his dislike of his employees' activities as a union; the temporary closing of the place of employment by the employer without formally discharging the employees, the object being to discourage union activities or to gain acceptance of his views or compromise, which is more favorable to him than the demands made by his employees; or
(6) an involuntary termination of **Employment** not due to willful or criminal misconduct: means a transgression of some established and definite rule of action, a forbidden act, a dereliction of duty,

willful in character, improper, or wrong behavior but not negligence or carelessness and unlawful behavior as determined by local, state, or federal law.

LOSS means an event of **Involuntary Unemployment**. For additional insurance coverage riders, loss is defined as provided by those riders.

MAXIMUM BENEFIT AMOUNT means the benefit amount shown in **Your Schedule**. In the event of a **Loss**, the **Maximum Benefit Amount** is payable to **You**. Benefit payments are subject to all terms and conditions of this **Policy**.

POLICY means the contract issued to the **Covered Person** providing the coverages described.

RE-ELIGIBILITY PERIOD means a specified time period as shown in the **Schedule** following the end of a **Benefit Period**.

If a claim for **Involuntary Unemployment** occurs within this specified **Re-Eligibility Period** during which **You** have returned to active full-time employment, the benefit is subject to the remaining benefits of the previous period of unemployment and will be considered a continuation of the previous claim. A new **Waiting Period** will not apply.

If a claim for **Involuntary Unemployment** occurs after the specified **Re-Eligibility Period** during which **You** have returned to active full-time employment, the **Loss** will be considered a new claim and a new **Waiting Period** will apply.

SEASONAL EMPLOYMENT means **Employment** that can only be carried on during certain seasons or during definite times of the year and where the customary period of **Employment** is less than 1,000 hours during a consecutive twelve (12) month period.

VESTING PERIOD, if any, means a period of consecutive time following the **Effective Date** of coverage shown in **Your Schedule** during which **You** are ineligible to file a claim or to receive benefits even if a **Loss** occurs. The **Vesting Period** for each coverage is shown in **Your Schedule**.

WAITING PERIOD means a period of consecutive time after a date of **Loss** during which no benefit is payable. The **Waiting Period** will not begin until the **Vesting Period** has been satisfied and **You** are eligible for benefits. The **Waiting Period** for each coverage is shown in **Your Schedule**.

WE, US and **OUR** means the insurer, American National Property And Casualty Company.

YOU, YOUR and **YOURS** means the **Covered Person**.

ELIGIBILITY

Individuals age 18 through 60 are eligible to apply for coverage.

Self-employed individuals and independent contractors may be eligible for **Involuntary Unemployment** Insurance coverage provided they meet all other eligibility requirements including qualifying for and receiving state unemployment benefits.

BENEFITS

Benefits are subject to all terms and conditions described in this **Policy**.

INVOLUNTARY UNEMPLOYMENT BENEFIT. Upon **Our** receipt of satisfactory written proof of **Loss** from **You,** and after any **Vesting Period** and **Waiting Period** has been satisfied, **We** will pay benefits according to the terms and conditions of this **Policy** and the coverage selected. If, after satisfaction of the **Waiting Period**, the period of **Involuntary Unemployment** is less than a full month, **We** will pay 1/30th of the monthly benefit for each day of that period.

You:

(1) are required to provide **Us** written proof of **Loss** of **Your** continuing **Involuntary Unemployment** on a monthly basis or at any time upon **Our** request.

(2) must register with **Your** state unemployment office for unemployment benefits, must be receiving those benefits and must continue to actively seek **Employment** through **Your** state employment office or a recognized employment agency beginning no later than thirty (30) days after loss of **Employment**.
(3) must remain actively registered with **Your** state unemployment office to remain eligible for benefits under this **Policy.**

Benefit payments will cease when **You** are no longer involuntarily unemployed or when benefits reach the maximum limits shown in the **Schedule**, whichever occurs first.

Any change to **Your Employment** status including, but not limited to, retirement, may result in ineligibility for **Involuntary Unemployment** coverage under this **Policy**. If **You** become ineligible as a result of a change in **Employment** status, **You** should contact **Us** at **Our Administrative Office**.

EXCLUSIONS

No benefit shall be paid if **You** are currently receiving benefits for any other **Loss** under this **Policy**, or if the **Loss** was caused by, resulted from, or was contributed to by:

(1) voluntary forfeiture of **Employment** salary, wages, or other **Employment** income;
(2) resignation of **Employment**;
(3) retirement from **Employmen**t;
(4) termination of **Employment** due to willful or criminal misconduct;
(5) Scheduled termination of **Employment** contract;
(6) termination of **Seasonal Employment**;
(7) a reduction in number of hours worked not resulting in total elimination of **Employment** income;
(8) having received notice, either orally or in writing, of pending unemployment within ninety (90) days prior to enrollment date;
(9) the failure of self-employed individuals and independent contractors to meet all eligibility requirements including qualifying for and receiving state unemployment benefits; or
(10) a **Loss** of **Employment** commencing before satisfaction of the **Vesting Period**.

RENEWAL CONDITION

You may renew this **Policy**, subject to the Individual Termination of Insurance and Premiums section. If **We** elect not to renew this **Policy**, **We** will provide advance written notice of nonrenewal to the **Covered Person** at the last mailing address known to **Us** at least thirty (30) days prior to the effective date of nonrenewal. The notice will state the reason(s) for nonrenewal; proof of mailing will be sufficient proof of notice.

We do not have the right to refuse a premium paid on or before the date due or within the Grace Period. **Your** coverage will expire if the premium is not paid by the last day of the Grace Period.

You may cancel this **Policy** at any time by providing written notice to **Us** at **Our Administrative Office**. Coverage will remain in force until the premium due date immediately following the date of **Your** cancellation.

INDIVIDUAL TERMINATION OF INSURANCE

This **Policy** may be terminated by **You** by providing **Us** at **Our Administrative Office** advance written notice of termination. **We** may terminate this **Policy** in the case of nonpayment of premium or discovery of fraud or material misrepresentation by **You**. **We** do not have the right to refuse a premium paid on or before the date due or within the Grace Period. Coverage will terminate if the premium is not paid by the end of the Grace Period.

Coverage under this **Policy** automatically ends on the premium due date immediately following:

(1) the date this **Policy** is terminated by **You**;
(2) the date **You** fail to pay the required premium by the date due, except as provided for in the grace period;
(3) **Your** attainment of age 65; or
(4) the date of **Your** death.

We may terminate this **Policy**. **We** will provide advance written notice of termination to **You** at least thirty (30 days prior to the date coverage will end. The notice will state the reason(s) for the proposed action and the effective date of termination; coverage will end on that date. Proof of mailing will be sufficient proof of notice.

Upon termination of coverage, premiums paid monthly have been fully earned and are non-refundable; coverage will continue until the next monthly premium due date. Termination of this **Policy** will not prejudice any claim originating prior its termination subject to all other terms and conditions contained herein.

PREMIUMS

PAYMENT OF PREMIUM. All premiums shall be paid to **Us** on or prior to the due date as stated in the **Schedule**. **You** are required to pay the premium shown in the **Schedule** to keep **Your** coverage in force.

PREMIUM CHANGES. We have the right to change the premium rates under this **Policy** by giving **You** at least thirty (30) days' advance written notice. Premium rates may also change at any time **You** make a coverage change request that **We** agree to accept.

GRACE PERIOD. If premium is not paid by the due date, the insurance shall be in default. After the first premium has been paid, **We** will allow a thirty (30) day Grace Period for future payments as allowed by the insurance laws in the state where coverage is issued. Coverage under this **Policy** will terminate if the premium is not paid by the end of the Grace Period.

CLAIM PROVISIONS

TO REPORT A CLAIM AND TO OBTAIN A CLAIM FORM. Contact **Our Administrative Office** at 1-866-453-5616, between 9:00 a.m. and 6:00 p.m. Eastern Time, Monday through Friday or mail **Your** request to **Our Administrative Office**. **We** will mail forms for filing proof of **Loss** to **You** within ten (10) business days. If these forms are not delivered to **You** within ten (10) days, **You** may meet the Proof of Loss requirements by providing **Us** a written statement of the nature and extent of the **Loss** as stated in the Proof of Loss provision.

NOTICE OF CLAIM. Written Notice of Claim must be provided to **Us** within thirty (30) days after the date of **Loss** or as soon thereafter as is reasonably possible. Failure to give such notice within the time frame specified will not invalidate or reduce the claim unless this failure operates to prejudice **Our** rights. The Notice of Claim should include the **Covered Person**'s name, the **Policy** Number, the **Effective Date** of coverage, and should be mailed to **Our Administrative Office**.

All proof of **Loss** forms must be completed by the **Covered Person** and such other persons or officials as may be required. A claim will be activated when all proof of **Loss** forms have been properly completed by all required parties and are received by **Our Administrative Office**.

PROOF OF LOSS. In the case of involuntary termination or layoff, satisfactory written evidence that **You** are receiving state unemployment benefits and have registered for work with **Your** state employment office or a recognized employment agency within thirty (30) days after **Loss** of **Employment** is required. Furthermore, written evidence that **You** remain registered and are actively seeking new **Employment** while benefits are being paid is also required.

In the case of a strike or lockout, satisfactory written evidence of **Involuntary Unemployment**, which may include a statement signed by a union officer, is required.

You must provide satisfactory written evidence of continuing **Involuntary Unemployment** on a monthly basis or any time upon **Our** request.

We may require the **Covered Person** to provide additional documents in order to satisfy proof of **Loss** and to determine **Our** liability. Additional documents must be provided no later than one (1) year from the date of **Loss**.

PAYMENT OF CLAIMS. Upon **Our** receipt of satisfactory written proof of **Loss** and determination of **Our** liability, benefits payable under the terms and conditions of this **Policy** will be paid within thirty (30) days.

All benefits are paid directly to **You**. If **You** become deceased, benefits will be payable to **Your** estate.

GENERAL PROVISIONS

CONFORMITY TO LAW. Any provision of this **Policy**, which, on its **Effective Date**, is in conflict with the insurance laws of the state in which **You** reside shall be amended to conform to the laws of that state.
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ENTIRE CONTRACT. This **Policy** of Insurance, together with the Application for Insurance, the Policy Schedule of Insurance, any insurance coverage riders, and any endorsements make up the entire contract of insurance. This **Policy** may be revised only by written agreement between the **You** and **Us**.

Only **Our** authorized officer(s) have authority to waive or otherwise revise any provision of this **Policy** or **Our** rights hereunder. Any action, statement, or agreement made in writing by any person(s) other than **Our** authorized officer(s), shall in no way bind or estop **Us** from enforcing the provisions of this **Policy** or **Our** rights hereunder. A written agreement which modifies, extends, or is in conflict with this **Policy** shall be invalid unless such written agreement is signed by **Our** authorized officer(s) and is made part of this **Policy**. An agent or broker cannot change or waive provisions within the entire contract.

MISSTATEMENT OF AGE. If, as a result of misstatement of age by **You**, **We** issue a **Policy** and accept premium for coverage, which would not have been in effect if based upon factual information, **Our** liability shall be limited to the return of premiums paid for the period coverage was in force.

MATERIAL MISREPRESENTATION, FRAUD, OUR RIGHT TO RESCIND. If **You** have concealed or misrepresented any material fact in the application for insurance or in the submission of any claim, or if **You** have attempted fraud, or false swearing and coverage was issued or benefits were paid in reliance upon those statements, **We** may deny the claim and, if applicable, rescind coverage. **Our** liability will be limited to the return of premiums paid, less any benefits paid.

RIGHT OF RECOVERY. If payments for claims exceed the maximum amount payable under the terms and conditions of Involuntary Unemployment Insurance coverage or insurance coverage riders under this **Policy**, **We** have the right to recover the excess of such payments.

LEGAL ACTIONS. No action can be brought to recover under this **Policy** until at least sixty (60) days after **We** have received satisfactory written proof of **Loss**. No such action shall be brought more than ten (10) years after the date **We** receive satisfactory proof of **Loss**.

INCOME TAXATION. Benefits paid do not include provisions for any income tax that may be owed by **You** or **Your** estate. **You** should consult **Your** own tax advisor regarding any tax consequences of benefits received under this **Policy**.

Authorized Officer

Authorized Officer

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TOTAL DISABILITY INSURANCE RIDER

This Total Disability Insurance Rider (hereinafter referred to as "**Rider**") is part of the Involuntary Unemployment Insurance Policy (hereinafter referred to as "**Policy**") to which it is attached. It is issued in consideration of the application and payment of the required premium.

Benefits are subject to all terms and conditions of the **Policy** to which it is attached.

This **Rider** does not waive, alter, or extend any provisions or limitations of the **Policy** except to the extent stated below.

DEFINITIONS

When used in this **Rider**, the following words and phrases have the meaning given.

ACCIDENT means a specific unexpected, unforeseen event for which a time and place or occurrence can be identified and which results in **Injury** sustained by a **Covered Person**. The **Accident** must occur after the **Effective Date** shown on the Policy Schedule of Insurance and while this **Rider** is in force.

COVERED PERSON means the **Covered Person** named on the Policy Schedule of Insurance.

INJURY means bodily injury caused by an **Accident** occurring while this **Rider** is in force which results in a **Loss**:

(1) directly and independently of all other causes; and
(2) within 365 days after the date of the **Accident**.

LOSS means the **Total Disability** of a **Covered Person,** which occurs while this **Rider** is in force.

PHYSICIAN means a doctor of medicine or an osteopath who is duly licensed by the state medical board and provides medical services within the scope of his or her license. Such doctor or osteopath must not be a person who is a member of a **Covered Person**'s immediate family. Practitioners of homeopathic or naturopathic medicine are not considered eligible **Physician**s.

SICKNESS means illness or disease for which a **Covered Person** is diagnosed or treated after the **Effective Date** of coverage and while this **Rider** is in force.

TOTAL DISABILITY means a **Covered Person**'s inability to perform normal daily activities due to an **Injury** or **Sickness**. The **Covered Person** must remain under the regular care of a **Physician** while totally disabled in order to remain eligible for benefits. The **Total Disability** must be confirmed by a **Physician**.

TOTAL AND PERMANENT DISABILITY means the **Covered Person** is totally and permanently disabled as confirmed by a **Physician**.

BENEFITS

Benefits payable under this **Rider** are subject to all **Policy** provisions.

TOTAL DISABILITY BENEFIT. Upon **Our** receipt of satisfactory proof of **Loss** confirming the **Total Disability** of a **Covered Person** as the result of a covered **Injury** or **Sickness**, **We** will pay the **Maximum Benefit Amount** shown in the Policy Schedule of Insurance.

The **Vesting Period**, if any, must be satisfied and the period of **Loss** of **Total Disability** must exceed the **Waiting Period** shown on the Policy Schedule of Insurance. Benefits will begin on the first day of **Total Disability** following satisfaction of the **Vesting Period** and **Waiting Period**. If after the **Waiting Period** has been satisfied and the **Covered Person**'s **Total Disability** includes a period of **Loss** less than a full month, **We** will pay 1/30th of the monthly **Maximum Benefit Amount** for each day of **Total Disability**.

Benefit payments will stop:

(1) on the date the **Covered Person** is no longer **Totally Disabled**; or
(2) when the Maximum Benefit Period shown on the Policy Schedule of Insurance has been reached.

The same continuous **Loss** is not eligible for more than one **Benefit Period**.

RE-ELIGIBILITY PERIOD means a specified time period as shown in the Policy Schedule of Insurance following the end of a **Benefit Period**.

If a claim for **Total Disability** occurs within this specified **Re-Eligibility Period** during which the **Covered Person** has returned to normal daily activities, the benefit is subject to the remaining benefits of the previous period of disability and will be considered a continuation of the previous claim. A new **Waiting Period** will not apply.

If a claim for **Total Disability** occurs after the specified **Re-Eligibility Period** during which the **Covered Person** has returned to normal daily activities, the **Loss** will be considered a new claim and a new **Waiting Period** will apply.

EXCLUSIONS

No benefit shall be paid if the **Covered Person** is currently receiving benefits for any other **Loss** under the **Policy** or for **Loss** caused by, resulting from, or contributed to by the occurrence of any of the following:

(1) normal pregnancy and/or childbirth except for complications of childbirth;
(2) the **Covered Person**'s attempted suicide or intentionally self-inflicted **Injury** while sane or insane;
(3) any **Sickness**, **Injury**, or other condition of physical or mental health for which the **Covered Person** was hospitalized or received medical or surgical treatment, including medication, consultation, advice, or therapy during the six (6) month period prior to the **Effective Date** of coverage and which caused or substantially contributed to **Total Disability** within six (6) months following the **Effective Date**;
(4) the **Covered Person**'s **Total Disability** due to **Sickness** that commenced before satisfaction of the **Vesting Period**; or
(5) any Injury of a **Covered Person** due to **Sickness**.

CLAIM PROVISIONS

TO REPORT A CLAIM AND TO OBTAIN A CLAIM FORM. Contact **Our Administrative Office** at 1-866-453-5616, between 9:00 a.m. and 6:00 p.m. Eastern Time, Monday through Friday or mail **Your** request to **Our Administrative Office**. **We** will mail forms for filing proof of **Loss** to the **Covered Person** within ten (10) business days. If these forms are not delivered to the **Covered Person** within ten (10) days, the **Covered Person** may meet the Proof of Loss requirements by providing **Us** a written statement of the nature and extent of the **Loss** as stated in the Proof of Loss provision.

NOTICE OF CLAIM. Written Notice of Claim must be provided to **Us** at **Our Administrative Office** within thirty (30) days after the date of **Loss** or as soon thereafter as is reasonably possible. Failure to give such notice within the time frame specified will not invalidate or reduce the claim unless this failure operates to prejudice **Our** rights. The Notice of Claim should include the **Covered Person**'s name, the **Policy** Number, the **Effective Date** of coverage, and should be mailed to **Our Administrative Office**.

All proof of **Loss** forms must be completed by the **Covered Person** and such other persons or officials as may be required. A claim will be activated when all proof of **Loss** forms have been properly completed by all required parties and are received by **Our Administrative Office**.

PROOF OF LOSS. In the case of **Total Disability**, the **Covered Person** must provide satisfactory written proof signed by the **Covered Person**'s **Physician** to **Us** at **Our Administrative Office** within thirty (30) days after the date of **Loss**, or as soon thereafter as is reasonably possible. Failure to provide satisfactory written proof in the time frame specified will not result in a denial of the claim unless this failure operates to prejudice **Our** rights.

We may require the **Covered Person** to provide additional documents in order to satisfy proof of **Loss** and to determine **Our** liability. Additional documents must be provided no later than one (1) year from the date of **Loss**.

We may require medical examination of the **Covered Person** performed by a **Physician** of **Our** choice. In the event of conflicting opinions, the opinion of the **Physician** chosen by **Us** will be conclusive. Upon **Our** request, the **Covered Person** must provide written authorization allowing his/her treating **Physician** or medical providers to discuss the **Total Disability** with **Us** and/or to release relevant medical records to **Us**.

The **Covered Person** must provide satisfactory written proof of continuing **Total Disability** on a monthly basis or any time upon **Our** request.

PAYMENT OF CLAIMS. Upon **Our** receipt of satisfactory proof of **Loss** and determination of **Our** liability, benefits for the **Total Disability** of the **Covered Person** will be payable under the terms and conditions of the **Policy** and this **Rider** within thirty (30) days.

All benefits are paid directly to the **Covered Person**.

GENERAL PROVISIONS

CONFORMITY TO LAW. Any provision of this **Policy**, which, on its **Effective Date**, is in conflict with the insurance laws of the state in which **You** reside shall be amended to conform to the laws of that state.

PHYSICAL EXAM. At **Our** expense, **We** may require a medical examination of the **Covered Person** as often as is reasonable while a claim is pending.

This **Rider** takes effect with the **Policy** to which it is attached.

Authorized Officer

Authorized Officer

AMERICAN NATIONAL PROPERTY AND CASUALTY COMPANY
"A Stock Insurance Company"

INVOLUNTARY UNEMPLOYMENT INSURANCE
WAIVER OF PREMIUM ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Under the **DEFINITIONS** section of the Involuntary Unemployment Insurance Policy the following is added:

WAIVER OF PREMIUM means premiums will be waived for a **Covered Person** during the time benefits are being paid on a claim.

ALL OTHER PROVISIONS OF THIS POLICY REMAIN UNCHANGED.