IMPORTANT NOTICES

If you reside in one of the following states, please read the important notices below:

Arizona, Florida and Maryland residents:

The group policy is issued in the state of New York and will be governed by its laws. If you reside in a state other than New York, this certificate of insurance may not provide all of the benefits and protections provided by the laws of your state. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Texas residents:

IMPORTANT NOTICE: To obtain information or make a complaint:

You may call Special Marketing Division's toll-free telephone number for information or to make a complaint at 1-800-441-1832.

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at 1-800-252-3439.

You may write the Texas Department of Insurance:
P O Box 149091
Austin, TX 78714-9104
FAX # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE: Para solicitar información o presentar una queja:

Llame a la línea gratuita de la División Especial de Marketing para obtener información o presentar una queja al 1-800-441-1832.

Puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas llamando al 1-800-252-3439.

También puede escribir al Texas Department of Insurance (Departamento de Seguros de Texas):
P O Box 149091
Austin, TX 78714-9104
FAX: (512) 475-1771

CONFLICTOS POR PRIMAS O RECLAMACIONES: En caso de tener un conflicto relacionado con su prima o una reclamación, debe comunicarse primero con el agente o la compañía. Si el conflicto no se resuelve, usted puede comunicarse con el Departamento de Seguros de Texas.
Washington Residents:

(In Accordance With WAC 284-23-610, 620, 650, 730)

The accelerated life benefit in this policy does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

If an Insured receives payment of accelerated benefits from a life insurance policy, he or she may lose the right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for the Insured. We cannot give advice about this. The Insured may wish to obtain advice from a tax professional or an attorney before he or she decides to receive accelerated benefits under a life policy.
NOTICE

BENEFITS PAID UNDER THE TERMINAL ILLNESS BENEFIT PROVISION WILL REDUCE THE DEATH BENEFIT PAYABLE FOR LIFE INSURANCE.

BENEFITS PAYABLE UNDER THE TERMINAL ILLNESS BENEFIT PROVISION MAY BE TAXABLE. IF SO, THE INSURED OR THE INSURED'S BENEFICIARY MAY INCU{R A TAX OBLIGATION. AS WITH ALL TAX MATTERS, AN INSURED SHOULD CONSULT WITH A PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

RECEIPT OF ACCELERATED BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS.

TERMINAL ILLNESS BENEFITS ARE NOT PAYABLE IF LIFE INSURANCE COVERAGE UNDER THIS POLICY IS NOT IN FORCE.

TY-005198
FOREWORD

Life insurance provides individuals and their families with financial protection. The Life Insurance Benefit described in this booklet will help secure your family's financial security in the event of your death.

The need for life insurance protection depends on individual circumstances and financial situations. A portion of the cost of this coverage is provided by your Employer. You may need to contribute to the remaining cost of coverage through payroll deduction so that your benefit program is more comprehensive and responsive to your needs.

The following pages describe the main provisions of the life insurance plan available to you.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.
We, the CIGNA LIFE INSURANCE COMPANY OF NEW YORK, certify that we have issued a Group Policy, FLY-960209, to Colgate University.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

Nothing in this group policy will invalidate or impair the rights granted to holders of any certificates issued under this policy, under the terms of the certificate or by law.

Matthew G. Manders, Senior Vice-President
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHEDULE OF BENEFITS</td>
<td>1</td>
</tr>
<tr>
<td>WHO IS ELIGIBLE</td>
<td>4</td>
</tr>
<tr>
<td>WHEN COVERAGE BEGINS</td>
<td>4</td>
</tr>
<tr>
<td>WHEN COVERAGE ENDS</td>
<td>5</td>
</tr>
<tr>
<td>CONTINUATION OF INSURANCE</td>
<td>6</td>
</tr>
<tr>
<td>LIFE INSURANCE BENEFITS</td>
<td>7</td>
</tr>
<tr>
<td>LIFE INSURANCE EXCLUSIONS</td>
<td>9</td>
</tr>
<tr>
<td>CLAIM PROVISIONS</td>
<td>10</td>
</tr>
<tr>
<td>ADMINISTRATIVE PROVISIONS</td>
<td>12</td>
</tr>
<tr>
<td>GENERAL PROVISIONS</td>
<td>12</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>13</td>
</tr>
</tbody>
</table>
SCHEDULE OF BENEFITS

Policy Effective Date: January 1, 2010
Certificate Effective Date: December 1, 2014
Policy Anniversary Date: January 1
Policy Number: FLY-960209

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active, Full-time Employees of the Employer scheduled to work a minimum of 1040 hours in a rolling 12 month period.

Your Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

If you were hired on or before the Policy Effective Date: No Waiting Period.
If you were hired after the Policy Effective Date: No Waiting Period.

LIFE INSURANCE BENEFITS

If an Insured is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the date of the change in class.

Employee Benefits

Basic Benefit 2 times your Annual Compensation rounded to the next higher $1,000, if not already a multiple thereof.

Minimum Benefit: $50,000
Guaranteed Issue Amount: the lesser of 2 times Annual Compensation or $300,000
Maximum Benefit: the lesser of 2 times Annual Compensation or $300,000

Voluntary Benefit 1 or 2 times your Annual Compensation rounded to the next higher $1,000, if not already a multiple thereof.

Guaranteed Issue Amount: the greater of a) or b) below:
a) the lesser of 2 times Annual Compensation or $200,000, or
b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit: the lesser of 2 times Annual Compensation or $200,000
Age Based Reductions

When you are age 65 or older, your Life Insurance Benefit will reduce to:

- 65% of the Life Insurance Benefit at age 65
- 50% of the Life Insurance Benefit at age 70

Benefits reductions will be effective on the Policy Anniversary Date coinciding with or next following the Employee’s attainment of age as specified in schedule above.

Terminal Illness Benefit

Maximum Benefit: $300,000

Automatic Increase Feature

If your Voluntary Life Insurance Benefit is based on Annual Compensation, it will automatically increase. The amount of the increase may be up to 25% of the Employee’s previous salary. It will automatically increase, subject to the conditions below.

Conditions for Automatic Increase:
1. you provide the Insurance Company with the required notice of an increase in Annual Compensation;
2. you are in Active Service on the effective date of the increase; and
3. the total benefit does not exceed the Guaranteed Issue Amount.

If you are not in Active Service on that date, your benefit will not increase until you return to Active Service.

You will be required to satisfy the Insurability Requirement for an increased amount if:
1. you initially elect a Voluntary Life Insurance Benefit that is less than or equal to the Guaranteed Issue Amount and your benefit plus the automatic increase would exceed it; and
2. you have not been approved by the Insurance Company for a Voluntary Life Insurance Benefit in excess of the Guaranteed Issue Amount.

An Automatic Increase will become effective on the date of your increase in Annual Compensation, or if later, the date the Insurance Company approves any required Insurability Requirement.

If you are initially approved for a Voluntary Life Insurance Benefit in excess of the Guaranteed Issue Amount, it will not increase in excess of the Maximum Benefit Amount.

You may stop the Automatic Increase Feature at any time. If you stop the feature, it may not be restarted at a later date.

An Automatic Increase will not start the two year contestability period (as described in the paragraph “Incontestability” under the General Provisions) anew.
**Spouse Benefits**

Voluntary Benefit
- Option 1: $5,000
- Option 2: $10,000

Guaranteed Issue Amount: the greater of a) or b) below:

- a) $10,000, or
- b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan

Terminal Illness Benefit
- Maximum Benefit: 75% of the Maximum Benefit applicable to Spouse Life Insurance Benefits.

**Dependent Child Benefits**

Voluntary Benefit
- Option 1: $2,000
- Option 2: $4,000

The Maximum Benefit for a Dependent Child who is less than 6 months old is $500.

You may select one of the options shown above for your Spouse. If you elect coverage for your Dependent Children, each eligible child will be insured for the amount corresponding to the option selected for your Spouse.

All Dependent Child benefits are Guaranteed Issue.

TY-005159
WHO IS ELIGIBLE

Employee Eligibility
If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the Policy Effective Date, or the day after you complete the Eligibility Waiting Period, if later.

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class.

If you have previously converted your insurance under the Policy, you will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your Life Insurance benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to you.

Except as noted in the Reinstatement Provision, if you terminate your coverage and later wish to reapply, or if you are a former Employee who is rehired, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if your insurance ends because you are no longer in an eligible class, but you continue to be employed by the Employer and within one year you become a member of an eligible class.

You must be in Active Service throughout the Eligibility Waiting Period to be eligible for coverage. The Eligibility Waiting Period will be extended by the number of days you are not in Active Service.

Spouse Insurance
If you are eligible to elect Spouse coverage, your Spouse is eligible to be insured on the date you are insured or the date he or she becomes your Spouse, if later.

For the purposes of eligibility, your Spouse must be your lawful Spouse and not divorced from, or widowed by you. He or she must be under age 70 to be eligible. In order to become insured, a Spouse must be eligible.

Dependent Child
If you are eligible to elect Dependent Child coverage, your Dependent Child is eligible to be insured on the date you are insured or on the date the child qualifies as your Dependent Child, if later.

In no event will a Dependent Child be eligible to become insured more than once under the Policy.

WHEN COVERAGE BEGINS

You, your Spouse and Dependent Children will be insured for an amount not to exceed the Guaranteed Issue Amount on the date you become eligible, if you are not required to contribute to the cost of this insurance.

If you are required to contribute to the cost of this insurance, you may elect insurance for yourself, your Spouse and Dependent Children only by authorizing payroll deduction in a form approved by the Employer and us. The effective date of this insurance depends on the date and amount of insurance elected.
If you elect coverage within 31 days after you, your Spouse or Dependent Children are eligible or during an Annual Enrollment Period, any amount that does not exceed the Guaranteed Issue Amount is effective on the latest of the following dates.
1. The Policy Effective Date.
2. The date payroll deduction is authorized for this insurance.
3. The date the completed enrollment form is received by the Employer or us.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date he or she qualifies as a Dependent Child.

If you are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

If an eligible Spouse or Dependent Child is:
1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
2. confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.

TY-005155-2

**Takeover Provision**

*Special Terms Applicable to Previously Insured Employees Not in Active Service*

If you are not in Active Service on the Policy Effective Date, you are not covered under the Policy. However, We agree to provide a death benefit equal to the lesser of:
1. the amount that would be due under this Policy (without regard to the Active Service provision), or
2. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:
1. the date you meet the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the When Coverage Ends provision;
3. 12 months after the Policy Effective Date; or
4. the last day you would have been covered under the Prior Plan if that plan was still in force.

TY-009030

**WHEN COVERAGE ENDS**

Coverage will end on the earliest of the following dates:
1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you, your Spouse or Dependent Children are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service;
6. for an Employee, Spouse or Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date your coverage ends, for any insured Spouse or Dependent Child.

TY-005156
CONTINUATION OF INSURANCE

Continuation for Temporary Leave of Absence, Temporary Layoff, Family Medical Leave or Sabbatical leave
If you are an Employee and your Active Service ends due to an Employer approved leave of absence, temporary layoff, family medical leave or sabbatical leave, your insurance will continue if the required premium is paid.

In these circumstances, your insurance may continue as follows.
1. For an Employer approved leave of absence, up to 12 months.
2. For temporary layoff, up to 3 months.
3. For an Employer approved family medical leave, up to 12 months.
4. For sabbatical leave, up to 24 months.

Extended Death Benefit with Waiver of Premium

Extended Death Benefit
If you become Disabled while insured under the Policy and are less than age 65, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment. No waiting period is required before Life Insurance Benefits are extended. Coverage will be extended until the earlier of the following dates:
1. The date you are no longer Disabled.
2. The date you fail to qualify for Waiver of Premium or fail to provide proof of Disability as indicated under Waiver of Premium.

In lieu of continuing coverage under this provision, the Conversion Privilege for Life Insurance is available to the Insured on the date continued insurance ends, or at any time while Life Insurance Benefits are continued under this option.

Amount of Insurance
If you die while you are Disabled and coverage is extended under this provision, we will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. We will pay benefits only if due proof of your continuous Disability is received within one year (except in the absence of legal capacity) of the date of the loss.

“Disability”/“Disabled” means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under the Employer’s plan.

“Regular Occupation” means the occupation you routinely perform at the time the Disability begins.

Waiver of Premium
If you submit satisfactory proof that you have been continuously Disabled for 9 months, coverage will be extended up to Age 70. Premiums are not required during the Waiver Waiting Period. If the Insured is Disabled and dies during the Waiver Waiting Period, we will pay the Death Benefit in accordance with the Amount of Insurance paragraph in the Extended Death Benefit section above.

Such proof must be submitted to us no later than 3 months after the date the Waiver Waiting Period ends. Premiums will continue to be waived from the date we agree in writing to waive premiums for you.

After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if you remain Disabled and submit satisfactory proof that Disability continues. Satisfactory proof must be submitted to us 3 months before the end of the 12-month period.
Amount of Insurance
If you die while you are Disabled and coverage is continued under this provision, we will pay a Death Benefit equal to the amount in effect on the date you became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. We will pay benefits only if due proof of your continuous Disability is received within one year (except in the absence of legal capacity) of the date of the loss.

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer Disabled.
2. The date you refuse to submit to any physical examination required by us.
3. The last day of the 12-month period of Disability during which you fail to submit satisfactory proof of continued Disability.
4. Age 70.

If the Policy is terminated while your coverage is being continued under Waiver of Premium, coverage will continue in accordance with the Termination of Waiver paragraph.

In lieu of continuing coverage under this provision, the Conversion Privilege for Life Insurance is available to the Insured on the date continued insurance ends, or at any time while Life Insurance Benefits are continued under this option. If the Insured converts his or her coverage prior to satisfying the Waiver Waiting Period and later qualifies for the Waiver of Premium Benefit under the Policy, he or she will be covered under the Policy provided the conversion policy is surrendered. If the conversion policy is rescinded, premiums paid for that policy will be refunded.

“Disability”/”Disabled” means because of Injury or Sickness you are unable to perform all the material duties of any occupation which you may reasonably be qualified based on education, training or experience.

WHAT IS COVERED
LIFE INSURANCE BENEFITS

Death Benefit
If an Insured dies, we will pay the Life Insurance Benefit in force for that Insured on the date of his or her death. The Amount of Life Insurance is shown in the Schedule of Benefits.

Accelerated Benefits
You will become insured under this Accelerated Benefits provision on the date you become insured for life insurance under the Policy if these benefits apply to your class under the Policy and these benefits were not previously payable to you.

If you execute an absolute assignment or transfer of ownership of your insurance, this benefit terminates with respect to your insurance.
Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance at the Insured's death. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision. The Conversion Privilege is not activated when Accelerated Benefits are paid.

**Terminal Illness Benefit**

We will pay a Terminal Illness Benefit if we determine you or your Spouse are Terminally Ill. The Benefit Determination Date is the date we determine you have a Terminal Illness.

The Terminal Illness Benefit is 75% of the Life Insurance Benefit in effect on the Benefit Determination Date. The Insured's premium will be based on the Life Insurance Benefit plus the amount paid as a Terminal Illness Benefit. A separate claim must be filed and established for Waiver of Premium in accordance with the provisions of the Waiver of Premium Benefit.

The Terminal Illness Benefit is payable only once in an Insured's lifetime.

**Determination of Terminal Illness**

For the purpose of determining the existence of a Terminal Illness, we will require you to submit the following proof.

1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to us, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

We may require, at our expense, you to be examined and a review of the documented evidence by a Physician of our choice.

"Terminal Illness" means a person is diagnosed by a Physician to have a prognosis of 12 months or less to live.

**Conversion Privilege for Life Insurance**

If coverage ends for any reason except non-payment of premium, any Insured may apply for a conversion policy of life insurance. You may also apply if your life insurance benefit is reduced due to a change in age, class or the Policy. Your insured Spouse may apply for a conversion policy of life insurance if his or her coverage ends or reduces at your death, or upon divorce or annulment of your marriage. If coverage for a Dependent Child ends or reduces at his or her attainment of the limiting age or at your death, he or she may apply for a conversion policy of life insurance. Conversion which becomes available due to a reduction in insurance will be permitted up to the amount of the reduction.

The Conversion Privilege is not activated when an Insured's Life Insurance Benefit is reduced due to payment of an Accelerated Benefit.

The conversion insurance may be a type of life insurance currently being offered for conversion by us at your age and in the amount requested. It may not be term insurance, except for the first year after your insurance ends. For that year, you may elect term insurance to precede to the permanent plan. It may not be an amount greater than Life Insurance Benefits under the Policy on the last day the Insured is covered under the Policy. Conversion life insurance will not provide accident, disability or other benefits. The conversion coverage will not exclude suicide occurring more than two years after the effective date of coverage under the Policy.
If we do not have an individual life insurance form which meets the requirements of this privilege, we will offer an individual life insurance policy of Connecticut General Life Insurance Company which does meet such requirements.

If coverage ends because the Policy is terminated or amended, or the Employer cancels participation under the Policy, and you are or become eligible for coverage under any group policy within 45 days, you may not convert an amount of insurance greater than the amount for which you were covered under the Policy, less the amount of life insurance for which you are eligible under the other policy.

To apply for conversion insurance, you must submit an application to us and pay the required premium within 31 days after coverage under this Group Policy ends. Evidence of insurability is not required. Premium for the conversion insurance will be based on your age and class of risk and the type and amount of coverage issued.

Conversion insurance will become effective on the 31st day after the date coverage under this Policy ends if your application has been received by us and the required premium is paid on that date. If you die during the conversion period, whether or not it is extended beyond 31 days, as described below, the amount of life insurance which could have been converted will be paid under this Policy regardless of whether you applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that type and amount of insurance under the Policy.

Notice of Conversion

You must be notified within 15 days before or after an event that results in termination, or reduction in your group life insurance, but if notice is given more than 15 days but less than 90 days after the event, the time period allowed for the exercise of the conversion privilege shall be extended to 45 days after giving notice. If such notice is not given within 90 days after the event, the time allowed for the exercise of the conversion privilege expires at the end of 90 days. Notice, for the purpose of this section, means written notice presented to you by the Policyholder or mailed to your last known address as reported by the Policyholder.

If you die during the extended conversion period, the amount of life insurance which could have been converted will be paid under this Policy, regardless of whether or not you applied for the conversion insurance. If your application for conversion insurance is received by us and the required premium is paid, Life Insurance Benefits will be payable under the conversion insurance.

LIFE INSURANCE EXCLUSIONS

If you commit suicide within 2 years from the date insurance under the Policy becomes effective, your Voluntary Life Insurance Benefits will be limited to a refund of the premiums paid on your behalf.

Except for any amount in excess of the Prior Plan's benefits, this exclusion will not apply to anyone covered under the Prior Plan for more than two years. If you were not insured for two years under the Prior Plan, credit will be given for the time you were insured.

Except for any amount of benefits in excess of the Prior Plan's benefits, this exclusion will not apply to you if you were covered under the Prior Plan for more than two years. If you were not insured for two years under the Prior Plan, credit will be given for the time you were insured.

If a Dependent Child commits suicide and is survived by other Dependent Children covered under your certificate, no refund of premiums will be paid.
CLAIM PROVISIONS

Notice of Claim
Written notice or notice by any other electronic or telephonic means authorized by us, must be given to us after a covered loss occurs or begins, or as soon as reasonably possible. If this notice is not given within a reasonable amount of time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Written notice can be given at our home office in New York, New York or to our agent. Notice should include the Policyholder's name and policy number and the Insured's name and address.
Written notice of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as reasonably possible.

Claim Forms
When we receive the notice of claim, we will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof or proof by any other electronic or telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. A claimant will be required to provide any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by us, for Accelerated Benefits must be furnished as soon as reasonably possible after the date of diagnosis. This proof must describe the occurrence, character and extent of the diagnosis for which claim is made.

In case of claim for any other loss, written proof or notice by any other electronic or telephonic means authorized by us, of loss must be given to us as soon as reasonably possible after the date of the loss for which a claim is made.

We will not deny or reduce any claim if it: 1) is not reasonably possible to furnish the required proof within that period; and 2) is shown that such proof of loss was given as soon as was reasonably possible.

Time of Payment
Any benefits due under the Policy for a loss, other than a loss for which the Policy provides installments, will be paid immediately upon receipt of due written proof of loss or proof by any other electronic/telephonic means authorized by us.

To Whom Payable
Death benefits for you will be paid to the beneficiary named in our records, if any, at the time of payment. If there is no named beneficiary or surviving beneficiary, or if you die while Disability Benefits are payable to you, we may, at our option, make direct payment to any of the following:
1. spouse of the Insured;
2. child or children of the Insured;
3. parents of the Insured;
4. sisters or brothers of the Insured; or
5. the estate of the Insured.
All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance Benefits, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

If we are to pay benefits to the estate or to a person who is incapable of giving a valid release, we may pay up to $500 at the Insured’s death to a person appearing to us to be equitably entitled by reason of having incurred expenses on behalf of the Insured for his or her burial. This good faith payment satisfies our legal duty to the extent of that payment. Any other accrued benefits which are unpaid at the Insured's death may, at our option, be paid either to the Insured's beneficiary or to the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other proceeds payable under the Policy, unless otherwise stated in the Policy, will be payable to the Insured.

**Change of Beneficiary**
You may change your beneficiary at any time by giving us written notice or notice by any other electronic or telephonic means authorized by us. The beneficiary's consent is not required for this or any other change which you may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the request form is received by us. When the request form is received, it will take effect as of the date of the form. If you die before the request form is received, we will not be liable for any payment that was made before receipt of the request form.

**Physical Examination and Autopsy**
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

**Legal Actions**
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic or telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

**Time Limitations**
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

**Physician/Patient Relationship**
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.
ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If an Insured's coverage amount is reduced due to acceleration of a Death Benefit, premium will be based on the amount of coverage in force on the day before the reduction took place. If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Your Grace Period
If your required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

Reinstatement of Insurance
Your insurance may be reinstated if your insurance ends because you are on an unpaid leave of absence.

Your insurance may be reinstated only if reinstatement occurs within five years from the date your insurance ends. For your insurance to be reinstated all of the following conditions must be met.
1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. A written request, or a request by any other telephonic or electronic means authorized by the Employer and the Insurance Company, for reinstatement must be received by us within 31 days from the date you return to Active Service.
4. The Insurability Requirement, if any, is satisfied.

Your reinstated insurance is effective on the date you return to Active Service if the required premium is paid. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation before your insurance ended, you will receive credit for any time that was satisfied.

GENERAL PROVISIONS

Entire Contract
The Policy, the application of the Policyholder (a copy of which is attached at issue), the Policyholder endorsements, riders, certificate and attached papers constitute the entire contract between the parties. If an application of any Employee is required, it may also be made a part of this contract, at our option.
Nothing in this Policy will invalidate or impair the rights granted to any certificateholders by their certificates or by law.

Incontestability
All statements made by the Policyholder, or by an Employee are deemed representations and not warranties. No statement will cause us to deny or reduce benefits or be used as a defense to a claim, unless a copy of the written instrument, signed by the claimant, containing the statement is, or has been, furnished to such person while such person is still living. In the event of his death or legal incapacity, the beneficiary or representative must receive a copy. After two years from the Employee's effective date of insurance, no such statement will cause insurance to be contested except for non-payment of premium. This also applies to any added or increased benefits, from the effective date of the addition or increase in benefits.

Misstatement of Age
If your age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

TY-005180-1
**Misstatement of Smoker Status**
SMOKER STATEMENT: If an Insured misstates his or her status as a non-Smoker an adjustment in premium will be made to reflect a Smoker’s rate. If an Insured has misstated his or her status as a non-Smoker and he or she dies, the Life Insurance Benefit will be reduced to the amount of insurance, which the premium would have purchased had the Insured correctly stated his or her status.

**Workers' Compensation Insurance**
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance.

**Assignment**
The Insurance Company will not be affected by any assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. We do not assume responsibility for the validity or sufficiency of an assignment. An assignment of the certificate will operate so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment will transfer all rights and obligations of the Insured, or of the owner if other than the Employee.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where it is contrary to law.

**Conformity with State Statutes**
Any provision of the Policy in conflict on the Policy Effective Date with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

**Male Pronoun**
The male pronoun as used herein will be deemed to include the female.

**Clerical Error**
Your coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error or delay is found, the premium will be adjusted fairly.

**Agency**
The Policyholder, Employer and plan administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

**DEFINITIONS**

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**Accident**
The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

**Active Service**
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.
1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.
You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

**Annual Compensation**
Annual Compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.

**Annual Enrollment Period**
The period in each calendar year agreed upon by your Employer and us when you may enroll for, or change benefit elections, under the Policy.

**Dependent Child**
Your unmarried child if he or she meets the following requirements:
1. A child from live birth to 26 years old;
2. A child who is 26 years old and primarily supported by you;
3. A child who is 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

The term child means a child born to or legally adopted by you. It also means a stepchild living with and financially dependent upon you provided written consent of a biological parent is given to insure such child.

**Employee**
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

**Employer**
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

**Full-time**
Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

**Injury**
Any bodily harm, including all related conditions and recurring symptoms of the injuries, that results directly or indirectly from an Accident and independently of all other causes.

**Insurability Requirement**
You will be considered to have satisfied the Insurability Requirement on the day we agree in writing to accept you as covered under the Policy. To determine a person's acceptability for insurance, we will require evidence of good health and may require it be provided at your own expense.
Insurance Company
The Insurance Company underwriting the Policy is CIGNA Life Insurance Company of New York. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, any applicable Insurability Requirement is met, the required premium is paid and your insurance is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether related by blood or marriage) of either you or your spouse, or a person living in your household.

Policy Anniversary
A Policy Anniversary is the date so stated on the Policy cover and the same date that follows every 12 months for as long as the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date so stated on the Policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date.

Sickness
The term Sickness means a physical or mental illness. It also includes pregnancy.

Smoker
Smoker means a person who has smoked cigarettes, cigars or used a pipe or chewing tobacco, nicotine chewing gum or snuff during the twelve months prior to the date he or she applied for coverage.

Spouse
Your current Spouse. Except as used in eligibility, for any coverages provided by this Policy, the term includes a spouse who is legally divorced from or widowed by you.

TY-005153-1
SAME SEX ELIGIBILITY RIDER

Rider to Policy/Certificate made a part of Group Policy No. FLY-960209
Effective Date of Rider: December 1, 2014

Eligible Classes to which this Rider Applies: Class 1

The Policy is changed as follows:

When “Spouse” or “lawful spouse” is used in the Policy, it shall mean:
1. Any person legally married to the Employee, and not legally separated from the Employee; and
2. A spouse of the same sex as the Employee, who was lawfully married to the Employee, but where the Employee and Spouse no longer reside in a state that treats the marriage as valid. This does not apply if
   (a) the marriage is ended through divorce or annulment; or
   (b) either the Employee or Spouse has married someone else.

Cigna Life Insurance Company of New York

Matthew G. Manders, President

TY-008995
SUPPLEMENTAL INFORMATION
for
Colgate University Health & Welfare Plan
required by the Employee Retirement Income Security Act of 1974

As a Plan participant in Colgate University's Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

• The Plan is established and maintained by Colgate University, the Plan Sponsor.

• The Employer Identification Number (EIN) is 15-0532078.

• The Plan Number is 513.

• The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, FLY-960209, issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK.

• The Plan Administrator is: Colgate University
  13 Oak Drive
  Hamilton, NY  13346
  315-228-7743

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

• The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)

• The agent for service of legal process is the Plan Administrator.

• The Plan of benefits is financed by the Employer and Employees.

• The date of the end of the Plan Year is December 31.
WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician’s name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company’s written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
Appeal Procedure for Denied Claims

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

YOUR RIGHTS AS SET FORTH BY ERISA

As a participant in Colgate University's Insurance Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.
IMPORTANT CHANGES FOR STATE REQUIREMENTS

If you reside in one of the following states, please read the important changes below. The provisions of your certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

California Residents:

Conversion Privilege for Life Insurance
Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
d. The person meets all other conditions for converting the insurance.

Conversion Amount - Insured’s life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee’s Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

Missouri residents:

Regardless of any language to the contrary in the Policy, suicide is no defense to payment of life insurance benefits. However, if an Insured commits suicide within 2 years from the date his or her insurance under the Policy becomes effective, and the Insurance Company can show that the Insured intended suicide at the time he or she applied for the insurance, life insurance benefits will be limited to a refund of premium paid on the Insured's behalf.

North Dakota residents:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the insured subsequent to the effective date, if any, is limited to one year from the effective date of the increase.
UNDERWRITTEN BY:
CIGNA LIFE INSURANCE COMPANY OF NEW YORK
a CIGNA company

Class 1
01/2015