Schedule of Benefits

COMPANY INFORMATION:

1. **Company:**

2. **Address:**

3. **Telephone**:

4. **Federal Tax Identification Number**:

5. **Name and Telephone Number of Contact Person for Participant Questions**:

6. **Name and Address of Agent for Service of Legal Process**:

7. **Name and Address of Third-Party Claims Administrator:**

8. **Plan Number**: 501

BENEFIT LIMITS

9. **Effective Date of Plan**:

10. **Combined Benefit Period**: weeks from the date of the Occurrence or Accident

11. **Indemnity Benefits**:
    - Waiting Period:
    - Percentage of Pre-Injury Pay:
    - Maximum Weekly Disability Benefit Amount:

12. **Combined Benefit Amount for All Benefits**:
    - Combined Benefit Amount Per Participant:
    - Combined Benefit Amount Per Occurrence:

SIGNATURE AND DATE:

The Company hereby adopts this Plan by signature of its authorized representative.

Signature and Title Date