

RELIANCE STANDARD LIFE INSURANCE COMPANY
1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't you may lose your right to appeal.

Reliance Standard Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Consumer Complaint Coordinator at
1-800-351-7500

Toll free: 1-800-351-7500

Email: consumer.complaints@rsli.com

Mail:

1700 Market Street
Suite 1200
Philadelphia, PA 19103-3938

The Texas Department of Insurance.

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439.

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail:

MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Reliance Standard Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO

Llame a: Consumer Complaint Coordinator al
1-800-351-7500

Teléfono gratuito: 1-800-351-7500

Correo electrónico: consumer.complaints@rsli.com:

Dirección postal:

1700 Market Street
Suite 1200
Philadelphia, PA 19103-3938

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico:

ConsumerProtection@tdi.texas.gov

Dirección postal:

MC 111-1A
P.O. Box 149091
Austin, TX 78714



reliancestandard

LIFE INSURANCE COMPANY

Home Office: Schaumburg, Illinois • Administrative Office: Philadelphia, Pennsylvania

POLICYHOLDER: Michaels Stores, Inc

POLICY NUMBER: GL 163862

EFFECTIVE DATE: July 1, 2021, as amended through December 1, 2024

ANNIVERSARY DATES: July 1, 2022 and each July 1st thereafter.

PREMIUM DUE DATES: The first premium is due on the Effective Date. Further premiums are due monthly, in advance, on the first day of each month.

The Policy is delivered in Texas and is governed by its laws and/or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended, where applicable.

We agree to provide insurance to you in exchange for the payment of premium and a signed Application. The Policy provides benefits for loss of life from injury or sickness. It insures the eligible persons for the amount of insurance shown on the Schedule of Benefits. The insurance is subject to the terms and conditions of the Policy.

The effective date of the Policy is shown above. Insurance starts and ends at 12:01 A.M., Local Time, at your main address. It stays in effect as long as premium is paid when due. The "TERMINATION OF THE POLICY" section of the GENERAL PROVISIONS explains when the insurance can be ended.

The Policy is signed by the President and Secretary.



Secretary



President

**GROUP LIFE INSURANCE
NON-PARTICIPATING**

This Group Life Policy amends the Group Life Policy previously issued to you by us. It is issued on December 17, 2024.

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

GROUP POLICY NUMBER: GL 163862

POLICY EFFECTIVE DATE: July 1, 2021, as amended through December 1, 2024

POLICY DELIVERED IN: Texas

ANNIVERSARY DATE: July 1st in each year

Application is made to us by: Michaels Stores, Inc

This Application is completed in duplicate, one copy to be attached to your Policy and the other returned to us.

It is agreed that this Application takes the place of any previous application for your Policy.

Signed at _____ this _____ day of _____

Policyholder: _____

By: _____
(Signature)

(Title)

Please sign and return.





*BC1COAPGL 16386212/01/2024*RSL

*BC2COAPMichaels Stores, Inc

RELIANCE STANDARD LIFE INSURANCE COMPANY
Philadelphia, Pennsylvania

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Signed at _____ this _____ day of _____

Policyholder: _____

By: _____
(Signature)

(Title)

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SCHEDULE OF BENEFITS

NAME OF SUBSIDIARIES, DIVISIONS OR AFFILIATES TO BE COVERED: ALL

"Affiliate" means any corporation, partnership, or sole proprietor under the common control of the Policyholder.

ELIGIBLE CLASSES: Each active, Full-time Team Member, except any person employed on a temporary or seasonal basis, according to the following classifications:

CLASS 1: United States and Canadian Senior Vice-President and above

CLASS 2: United States and Canadian Vice-President

CLASS 3: United States and Canadian Director Level Team Member

The term "Team Member" as shown in Eligible Classes above, shall replace the term "employee" as shown throughout this Policy.

WAITING PERIOD: 30 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month coinciding with or next following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 30 Days

MINIMUM PARTICIPATION REQUIREMENTS: Percentage: 100% Number of Insureds: 10

AMOUNT OF INSURANCE:

Basic Life:

CLASS 1: \$1,000,000, not to exceed five (5) times Earnings.

CLASS 2: \$500,000, not to exceed five (5) times Earnings.

CLASS 3: \$250,000, not to exceed five (5) times Earnings.

For Insureds age 70 and over, the Amount of Basic Life Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Basic Life Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 70 or over on their Individual Effective Date.

Age	Percentage of available or in force amount at age 69
70+	50%

The Life amount will be reduced by any benefit paid under the Accelerated Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE:

CLASS 1 & 2: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the date of the change.

With respect to increases in the Amount of Insurance, the Insured must be Actively At Work on the date of the change. If an Insured is not Actively At Work when the change should take effect, the change will take effect on the day after the Insured has been Actively At Work in an Eligible Class for one full day.

CLASS 3: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the date of the change.

With respect to increases in the Amount of Insurance, the Insured must be Actively At Work on the date of the change. If an Insured is not Actively At Work when the change should take effect, the change will take effect on the day after the Insured has been Actively At Work in an Eligible Class for one full day.

CONTRIBUTIONS: Persons: Basic Insurance: 0%

DEFINITIONS

"We," "us" and "our" means Reliance Standard Life Insurance Company.

"You," "your" and "yours" means the employer, union or other entity to which the Policy is issued and which is deemed the Policyholder.

"Eligible Person" means a person who meets the eligibility requirements of the Policy.

"Insured" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at Work" and "Active Work" means the person actually performing on a Full-time basis each and every duty pertaining to his/her job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

"Full-time" means working for you for a minimum of 30 hours during a person's regularly scheduled work week.

"The date he/she retires" or "retirement" means the effective date of an Insured's:

- (1) retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with you;
- (2) retirement pension benefits under any plan which you sponsor, or make or have made contributions; or
- (3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means the Insured's annual salary received from you on the day just before the date of loss, prior to any deductions to a 401(k) and Section 125 plan. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary.

"Total Disability", as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means an Insured's complete inability to engage in any type of work for wage or profit for which he/she is suited by education, training or experience.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract between you and us is this Policy, your application (a copy of which is attached at issue), and any endorsements and amendments.

CHANGES

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing. It must also be signed by one of our executive officers and attached to this Policy.

INCONTESTABILITY

Any statement made in your application will be deemed a representation, not a warranty. We cannot contest the validity of this Policy after it has been in force for two (2) years from the date of issue, except for non-payment of premium. All other Policy terms will remain applicable.

Any statements made by you, any Insured, or on behalf of any Insured to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

- (1) No statement will be used in a contest unless:
 - (a) it is in a written form signed by the Insured, or on behalf of the Insured; and
 - (b) a copy of such written instrument is or has been furnished to the Insured, the Insured's beneficiary or legal representative.
- (2) If the statement relates to an Insured's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during the lifetime of the Insured.

RECORDS MAINTAINED

You must maintain records of all Insureds. Such records must show the essential data of the insurance, including new persons, terminations, changes, etc. This information must be reported to us regularly. We reserve the right to examine the insurance records maintained at the place where they are kept. This review will only take place during normal business hours.

CLERICAL ERROR

Clerical errors in connection with this Policy or delays in keeping records for this Policy, whether by you, us, or the Plan Administrator:

- (1) will not terminate insurance that would otherwise have been effective; and
- (2) will not continue insurance that would otherwise have ceased or should not have been in effect.

Clerical errors include (but are not limited to) the payment of premium for coverage not provided by this Policy. If appropriate, a fair adjustment of premium will be made to correct a clerical error. Such adjustments will be limited to the twelve (12) month period preceding the date we receive proof from you that an adjustment due to overpayment of premium should be made or the date we discover that premium has been underpaid.

MISSTATEMENT OF FACTS

If relevant facts about any person were misstated:

- (1) an adjustment of the premium will be made; and
- (2) the true facts will decide what amount of insurance is valid under this Policy.

If any misstated fact impacts the amount of premium that should have been paid, any benefit payable shall be in the amount the paid premium would have purchased based on the correct fact(s).

ASSIGNMENT

Ownership of any benefit provided under this Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

CONFORMITY WITH STATE LAWS

Any section of this Policy, which on its effective date, conflicts with the laws of the state in which this Policy is issued, that is not otherwise pre-empted, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE

We will send to you a certificate for distribution to each Insured and you agree to distribute a certificate to each Insured. The certificate will outline the insurance coverage and to whom benefits are payable.

POLICY TERMINATION

You may cancel this Policy at any time by providing us with written notice. This Policy will be cancelled on the date we receive your letter or, if later, the date requested in your letter.

We may cancel this Policy if:

- (1) the premium is not paid at the end of the grace period; or
- (2) the number of Insureds is less than the Minimum Participation Number on the Schedule of Benefits; or
- (3) the percentage of eligible persons insured is less than the Minimum Participation Percentage on the Schedule of Benefits.

If we cancel because of (1) above, the Policy will be cancelled at the end of the grace period. If we cancel because of (2) or (3) above, we will give you thirty-one (31) days written notice prior to the date of cancellation.

You will still owe us any premium that is not paid up to the date the Policy is cancelled. We will return, pro-rata, any part of the premium paid beyond the date the Policy is cancelled.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

GENERAL GROUP: The general group will be your employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBILITY REQUIREMENTS: A person is eligible for insurance under this Policy if he/she:

- (1) is a member of an Eligible Class, as shown on the Schedule of Benefits page; and
- (2) has completed the Waiting Period, as shown on the Schedule of Benefits page.

WAITING PERIOD: A person who is continuously employed on a Full-time basis with you for the period specified on the Schedule of Benefits has satisfied the Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If you pay the entire premium, the insurance for an Eligible Person will go into effect on the date stated on the Schedule of Benefits.

If an Eligible Person pays a part of the premium, he/she must apply in writing for the insurance to go into effect. He/she will become insured on the later of:

- (1) the Individual Effective Date stated on the Schedule of Benefits, if he/she applies on or before that date; or
- (2) the first of the month coinciding with or next following the date he/she applies, if he/she applies within thirty-one (31) days from the date he/she first met the eligibility requirements; or
- (3) the first of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if a person applies:
 - (a) after thirty-one (31) days from the date he/she first becomes eligible; or
 - (b) after he/she terminated this insurance but he/she remained in a class eligible for this insurance; or
 - (c) for an Amount of Insurance greater than the guaranteed issue Amount of Insurance shown on the Schedule of Benefits, if applicable; or
 - (d) for an Amount of Insurance greater than he/she was insured for under the prior group life insurance plan carrier, if applicable; or
 - (e) after being eligible for coverage under a prior group life insurance plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or
- (4) the date premium is remitted.

Proof of good health forms are available from us upon request. It is your responsibility to provide proof of good health forms to your employees when required.

Changes in an Insured's Amount of Insurance are effective as shown on the Schedule of Benefits.

If the Eligible Person is not Actively at Work on the day his/her insurance is to go into effect, the insurance will go into effect on the day he/she returns to Active Work in an Eligible Class for one full day.

TERMINATION OF INDIVIDUAL INSURANCE: The insurance of an Insured will terminate on the first of the following to occur:

- (1) the date this Policy terminates; or
- (2) the date the Insured ceases to be in a class eligible for this insurance; or
- (3) the end of the period for which premium has been paid for the Insured; or
- (4) the date the Insured enters military service on active duty (not including Reserve or National Guard).

CONTINUATION OF INDIVIDUAL INSURANCE: The insurance of an Insured may be continued, by payment of premium, beyond the date the Insured ceases to be eligible for this insurance, but not longer than:

- (1) twelve (12) months, if due to illness or injury; or
- (2) one (1) month, if due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if a former Insured is:

- (1) on an approved leave of absence; or
- (2) on temporary lay-off.

The former Insured must return to Active Work with you within the period of time shown on the Schedule of Benefits. He/she must also be a member of a class eligible for this insurance.

The former Insured will not be required to fulfill the Waiting Period of this Policy again. The insurance will go into effect on the day he/she returns to Active Work for one full day. If a former Insured returns after having resigned or having been discharged, he/she will be required to fulfill the Eligibility Requirements of this Policy again.

If an Eligible Person requests insurance after previously terminating insurance at his/her request or for failure to pay premium when due, proof of good health must be approved by us before his/her insurance coverage may be reinstated.

CONVERSION PRIVILEGE

An Insured can use this privilege when his/her insurance is no longer in force. It has several parts. They are:

- A. If the insurance ceases due to termination of employment or membership in any of this Policy's classes, an individual Life Insurance Policy may be issued. The Insured is entitled to a policy without disability or supplemental benefits. A written application for the policy must be made by the Insured within thirty-one (31) days after he/she terminates. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:
 - (1) The policy will, at the option of the Insured, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;
 - (2) The policy issued will be for an amount not over what the Insured had before he/she terminated;
 - (3) The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and the Insured's age at date of policy issue; and
 - (4) Proof of good health is not required.
- B. If the insurance ceases due to the termination or amendment of this Policy, an individual Life Insurance Policy can be issued. An Insured must have been insured for at least five (5) years under this Policy and/or the prior carrier. The same rules as in A above will be used, except that the face amount will be the lesser of:
 - (1) The amount of the Insured's Group Life benefit under this Policy. This amount will be less any amount he/she is entitled to under any group life policy issued by us or another insurance company; or
 - (2) \$2,000.
- C. If the insurance reduces, as may be provided in this Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.
- D. If an Insured dies during the time provided in A above in which he/she is entitled to apply for an individual policy, we will pay the benefit under the Group Policy that he/she was entitled to convert. This will be done whether or not the Insured applied for the individual policy.
- E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.

PREMIUMS

PREMIUM PAYMENT: All premiums are to be paid by you to us, or to an authorized agent, on or before the due date. The premium due dates are stated on the Policy face page.

PREMIUM RATE: The premium due will be the rate per \$1,000 of benefit multiplied by the entire amount of benefit volume then in force. We will furnish to you the premium rate on the Policy effective date and when it is changed. We have the right to change the premium rate:

- (1) on any premium due date after the Policy is in force for 36 months;
- (2) when the extent of coverage is changed by amendment; or
- (3) on any premium due date on or after the Policy is in force for 12 months if the entire amount of the benefit volume changes by 15% or more from the entire amount of benefit volume on the Policy effective date.

We will not change the premium rate due to (1) or (3) above more than once in any twelve (12) month period. We will tell you in writing at least sixty (60) days before the date of a change due to (1) or (3) above.

GRACE PERIOD: You may pay the premium up to 90 days after the date it is due. The Policy stays in force during this time. If the premium is not paid during the grace period, the Policy will be cancelled at the end of the grace period. You will still owe us the premium up to the date the Policy is cancelled.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by the Insured to receive benefits at the Insured's death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date the Insured signs it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If the Insured names more than one beneficiary to share the benefit, he/she must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if the Insured wishes to change the designation. His/her consent is also not needed to make any changes in this Policy.

If the beneficiary dies at the same time as the Insured, or within fifteen (15) days after his/her death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise.

If the Insured has not named a beneficiary, or the named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

- (1) the Insured's legal spouse;
- (2) the Insured's surviving child(ren) (including legally adopted child(ren)), in equal shares;
- (3) the Insured's surviving parents, in equal shares;
- (4) the Insured's surviving siblings, in equal shares; or, if none of the above,
- (5) the Insured's estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed \$1,000.

If the Insured has not named a beneficiary, or the named beneficiary is not surviving at the Insured's death, we may pay up to \$250 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with the Insured's last illness, death or burial.

The balance of the benefit, if any, will be held by us, until an individual or representative:

- (1) is validly named; or
- (2) is appointed to receive the proceeds; and
- (3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.

SETTLEMENT OPTIONS

The Insured may elect a different way in which payment of the Amount of Insurance can be made. He/she must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under \$2,000 or option payments of less than \$20.00 each are not eligible.

If no instructions for a settlement option are in effect at the death of the Insured, the beneficiary may make the election, with our consent.

OPTION A – FIXED TIME PAYMENT OPTION

Equal monthly payments will be made for any period chosen, up to thirty (30) years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change it. This change will apply only to requests for settlement elected after this change.

Option A Table
Minimum Monthly Payment Rates for each \$1,000 Applied

Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment	Years	Monthly Payment
1	\$83.71	7	\$12.32	13	\$6.83	19	\$4.81	25	\$3.76
2	42.07	8	10.83	14	6.37	20	4.59	26	3.64
3	28.18	9	9.68	15	5.98	21	4.40	27	3.52
4	21.24	10	8.75	16	5.63	22	4.22	28	3.41
5	17.08	11	7.99	17	5.33	23	4.05	29	3.31
6	14.30	12	7.36	18	5.05	24	3.90	30	3.21

OPTION B – FIXED AMOUNT PAYMENT OPTION

Each payment will be for an agreed fixed amount. The amount of each payment may not be less than \$10.00 for each \$1,000 applied. Interest will be credited each month on the unpaid balance and added to it. This interest will be at a rate set by us, but not less than the equivalent of 1% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

OPTION C – INTEREST PAYMENT OPTION

We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 1% per year.

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the proper representative of the beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the three (3) set out above may be made. A mutual agreement must be reached between the individual entitled to elect and us.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

- (1) the Insured becomes totally disabled prior to age 60;
- (2) the Total Disability begins while he/she is insured;
- (3) the Total Disability begins while this Policy is in force;
- (4) the Total Disability lasts for at least 9 months;
- (5) the premium continues to be paid; and
- (6) we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Insured is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask the Insured to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. The Insured may be required to be examined by a Physician approved by us as part of the proof. We will not require the Insured to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage on the life of the Insured that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if the Insured had not been totally disabled. If the Insured dies, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for an Insured will cease on the earliest of:

- (1) the date he/she no longer meets the definition of Total Disability; or
- (2) the date he/she refuses to be examined; or
- (3) the date he/she fails to furnish the required proof of Total Disability; or
- (4) the date he/she becomes age 70; or
- (5) the date he/she retires.

The Insured may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. An Insured is not entitled to conversion if he/she returns to work and is again eligible for the insurance under this Policy. If the Insured uses the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name, the Policy Number and your name.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within fifteen (15) days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within ninety (90) days. If it is not reasonably possible to give proof within ninety (90) days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to the Insured if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have an Insured examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina and Michigan, six (6) years) from the time written proof of loss is required to be submitted.

**EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES
EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Family and Medical Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependent, if applicable, in accordance with your policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

- (1) the premium for such Insured and his/her Insured Dependents, if applicable, continues to be paid during the leave; and
- (2) you have approved the Insured's leave in writing and provide a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

- (1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
- (2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue the Insured's coverage and that of any Insured Dependents, if applicable, in accordance with your policies regarding Military Services Leave of Absence under USERRA if the premium for such Insured and his or her Insured Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

This Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While the Insured is on a Family and Medical Leave of Absence for any reason other than his or her own illness, injury or disability or Military Services Leave of Absence he or she will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective for an Insured who is not considered Actively at Work until the Insured has returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in this Policy.

The Insured's coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

- (1) the date this Policy terminates; or
- (2) the end of the period for which premium has been paid for the Insured; or
- (3) the date such leave should end in accordance with your policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should you choose not to continue the Insured's coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, the Insured's coverage as well as any dependent coverage, if applicable, will be reinstated.

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT. THE ACCELERATION OF LIFE INSURANCE BENEFITS OFFERED UNDER THIS RIDER IS INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER THE INTERNAL REVENUE CODE OF 1986. IF THE ACCELERATION OF LIFE INSURANCE BENEFITS IS TAX-QUALIFIED UNDER THE INTERNAL REVENUE CODE OF 1986, THE BENEFITS WILL NOT BE TAXABLE. TAX LAWS RELATING TO ACCELERATION OF LIFE INSURANCE BENEFITS ARE COMPLEX. THE INSURED IS ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR ABOUT THE TAX CONSEQUENCES OF OBTAINING ACCELERATION OF LIFE INSURANCE BENEFITS.

RECEIPT OF ACCELERATION OF LIFE INSURANCE BENEFITS MAY AFFECT YOUR, YOUR SPOUSE OR YOUR FAMILY'S ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC), SUPPLEMENTARY SOCIAL SECURITY INCOME (SSI), AND DRUG ASSISTANCE PROGRAMS. YOU ARE ADVISED TO CONSULT WITH A QUALIFIED TAX ADVISOR AND WITH SOCIAL SERVICE AGENCIES CONCERNING HOW RECEIPT OF SUCH A PAYMENT WILL AFFECT YOU, YOUR SPOUSE AND YOUR FAMILY'S ELIGIBILITY FOR PUBLIC ASSISTANCE.

Attached to Group Policy Number: GL 163862
Issued to Group Policyholder: Michaels Stores, Inc

This Rider is attached to and made a part of the Policy indicated above. The Policy is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as "we", "us", "our".

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured's Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Policy at the death of the Insured, subject to all Policy provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means the primary Insured and his/her insured Dependents, if any.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured's illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in 24 months or less.

"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

DESCRIPTION OF COVERAGE: This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

- (1) the Insured must make a Written Request; and
- (2) we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense. If the second medical exam produces a conflicting diagnosis, we would arrange for a third medical exam to be performed at our own expense. The initial terminal diagnosis would then be honored only if it is confirmed by the third opinion.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of \$500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Accelerated Benefit is payable one time only for any Insured under this Rider.

EFFECT OF BENEFIT: If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

- (1) The Death Benefit payable for such Insured will be reduced by the amount equal to the Accelerated Benefit paid to such Insured. The amount of the Accelerated Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.
- (2) Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

If the Insured elects to receive the Accelerated Benefit, we will send him (and any irrevocable beneficiary) a statement showing the effect that payment of this benefit will have on the death benefit.


MISSTATEMENT OF AGE OR SEX: The Accelerated Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

TERMINATION OF AN INDIVIDUAL'S COVERAGE UNDER THIS RIDER: The coverage of any Insured under this Rider will terminate on the first of the following:

- (1) the date his coverage under the Policy terminates;
- (2) the date of payment of the Accelerated Benefit for his Terminal Illness; or
- (3) the date he attains age 75.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herein.

In witness whereof, we have caused this Rider to be signed by our Secretary.


Secretary

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)**

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, **ONLY** if the following conditions are met:
 1. The policyholder has a policy with a company domiciled in Texas;
 2. The policyholder's state of residence has a similar guaranty association; and
 3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov