GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

Legal Services for New York City

GROUP LIFE INSURANCE

CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. GL 131452 issued to Legal Services for New York City, the Policyholder.

When loss of life covered under the Policy occurs, we will pay the amount stated on the Schedule of Benefits to the named beneficiary, subject to provisions entitled Beneficiary and Facility of Payment.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

Secretary President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate amends all previous Group Life Certificates and is dated April 17, 2007.

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SCHEDULE OF BENEFITS

EFFECTIVE DATE: January 1, 2002, as amended in the Policy through January 1, 2007

ELIGIBLE CLASSES: Each active, Full-time and Part-time Employee, except an employee covered in any other class and any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The day you become eligible.

INDIVIDUAL REINSTATEMENT: 6 months

AMOUNT OF INSURANCE:

Basic Life: One and one half (1 1/2) times Earnings, rounded to the next higher $1,000, subject to a maximum of $225,000.

Amounts of basic insurance over $200,000 are subject to our approval of your proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF INSURANCE) will be at no expense to us.

The Amount of Basic Life Insurance will be reduced to 65% of the pre-age 65 amount at age 65; further reduced to 42% of the pre-age 65 amount at age 70 and terminates at retirement.

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

CHANGES IN AMOUNT OF INSURANCE: Changes in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the date of the change, provided you are Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

CONTRIBUTIONS: You are not required to contribute towards the cost of this insurance.*

For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Benefit might be treated as taxable. It is recommended that you contact your personal tax advisor.

*However, Management employees may elect to contribute 100% of the premium, in which case, your Benefit might be treated as non-taxable.

DEFINITIONS

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

"You," "your" and "yours" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at work" and "active work" means actually performing on a Full-time or Part-time basis each and every duty pertaining to your 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 the Policyholder for a minimum of 30 hours during your regularly scheduled work week.

"Part-time" means working for the Policyholder for a minimum of 21 hours during your regularly scheduled work week.

"The date you retire" or "retirement" means the effective date of your:

(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 the Policyholder;
(2) retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
(3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act while you are receiving the retirement pension benefits from the Policyholder.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from the Policyholder on the day just before the date of loss, prior to any deductions to a 401(k) plan. Earnings do not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

"Total Disability" as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means your complete inability to engage in any type of work for wage or profit for which you are suited by education,

training or experience.

GENERAL PROVISIONS

ENTIRE CONTRACT

The entire contract between the Policyholder and us is the Policy, the Policyholder's application (a copy of which is attached at issue), and any riders, endorsements and amendments. The rights of the Policyholder, your rights or the rights of any beneficiary shall not be affected by any provision other than one contained in the Policy, any riders, endorsements or amendments signed by the Policyholder and us or in the Policyholder's application attached to the Policy.

CHANGES

No agent has authority to change or waive any part of the 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 the Policy.

INCONTESTABILITY

Any statement made by you will be deemed a representation, not a warranty. We cannot contest the Policy after it has been in force for two (2) years, except for non-payment of premiums. No statement made by you can be used in a contest after your insurance has been in force during your lifetime for two (2) years. No statement by you can be used in a contest unless it is in writing and signed by you and given to you, your beneficiary or legal representative.

RECORDS MAINTAINED

The Policyholder 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

If a clerical error is made, it will not affect your insurance. No error will begin or continue your insurance prior to the date it should begin or beyond the date it should end under the Policy terms, if the error had not been made.

MISSTATEMENT OF AGE

If your age is misstated, the premium will be equitably adjusted. If your insurance is affected by the misstated age, the insurance coverage will be changed to the amount you are entitled to at your correct age.

ASSIGNMENT

Where there is no Third Party ownership, you may assign your interest under the Policy. If you do, all rights under the Policy are transferred to the new owner. If there is an irrevocable beneficiary, you must have his/her written consent to assign the insurance. No assignment will affect us unless it is in writing and is sent to us at our Office. When we receive the assignment, it will take effect as of the date it is signed. We are not liable for any action we take before we record it. We're not responsible for the validity of the assignment.

Where Third Party ownership applies, we will recognize the Third Party owner designated by you. That person will be considered the sole owner with all rights of ownership. These include the right to change the beneficiary, receive payment of claims and assign the insurance.

CONFORMITY WITH STATE LAWS

Any section of the Policy, which on its effective date, conflicts with the laws of the state in which the Policy is issued, is amended by this provision. This Policy is amended to meet the minimum requirements of those laws.

CERTIFICATE OF INSURANCE

We will send to the Policyholder an individual certificate for you. The certificate will outline the insurance coverage and to whom benefits are payable.

TERMINATION OF THE POLICY

The Policyholder may cancel the Policy at any time. The Policy will be cancelled on the date we receive the Policyholder's letter or, if later, the date requested in the Policyholder's letter.

We may cancel the 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.

The Policyholder 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 the Policyholder's employees and employees of any subsidiaries, divisions or affiliates named on the Schedule of Benefits.

ELIGIBLE CLASSES: The eligible classes will be those persons described on the Schedule of Benefits.

EFFECTIVE DATE OF INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the date stated on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the date stated on the Schedule of Benefits, except that the insurance will go into effect:

(1) on the date you apply, if you apply within thirty-one (31) days of the date you are first eligible; or

(2) on the date we approve any required proof of good health. We require proof of good health if you apply:

   (a) after thirty-one (31) days from the date you first become eligible; or

   (b) after you terminated this insurance but remained in a class eligible for this insurance.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

If you are not actively at work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to active work for one full day.

TERMINATION OF INSURANCE: Your insurance will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for you; or

(4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INSURANCE: Your insurance may be continued by payment of premium beyond the date you cease 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.

REINSTATEMENT: Your insurance may be reinstated if it was terminated while you were:

(1) on an approved leave of absence, or

(2) on a temporary lay-off.

You must return to active work within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

You will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to active work. If you return after having resigned or having been discharged, you will be required to fulfill the eligibility requirements of the Policy again.

If you return after terminating at your own request or for failure to pay premium when due, proof of good health must be approved by us before you may be reinstated.

CONVERSION PRIVILEGE

You can use this privilege when your 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 the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. 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 your option, be on any one of our forms, other than term life insurance (except as described in C below). 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 you had before you 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 your 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 the 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 be less any amount you are entitled to under any other group life policy issued or reinstated by us or another insurance company within forty-five (45) days after the date insurance coverage ceases.

C. An individual term Life Insurance Policy may, at your option, be issued for a period of one year immediately preceding the issuance of a Life Insurance Policy described in A or B above. The same rules as in A above will be used.

D. If the insurance reduces, as may be provided in the 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.

E. If you die during the time in which you are entitled to apply for an individual policy and you did not apply for such policy before your death, then we will pay the benefit under the Group Policy that you were entitled to convert.

F. Any policy issued with respect to A, B, C or D above will be put in force at the end of the thirty-one (31) day period in which application must be made.

NOTICE OF CONVERSION

G. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right within fifteen (15) days before or after the termination or reduction of your insurance. Such notice must be: (1) in writing; and (2) presented or mailed to you at your last known address by the Policyholder or by us at your last known address furnished to us by the Policyholder. If you are given notice more than fifteen (15) days after termination or reduction but less than ninety (90) days, you will have an additional period within which to convert. This additional period will end forty-five (45) days after you are given notice. However, this period will not extend beyond ninety (90) days after the date of termination or reduction of the insurance. This insurance will not be continued beyond the period provided above.

BENEFICIARY AND FACILITY OF PAYMENT

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

If you name more than one beneficiary to share the benefit, you 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 you wish to change the designation. His/her consent is also not needed to make any changes in the Policy.

If the beneficiary dies at the same time as you, or within fifteen (15) days after your death but before we received written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

(1) your legal spouse;
(2) your surviving children (including legally adopted children), in equal shares;
(3) your surviving parents, in equal shares;
(4) your surviving siblings, in equal shares; or, if none of the above,
(5) your 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 you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to $500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your 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

You may elect a different way in which payment of the Amount of Insurance can be made. You must provide a written request to us, for our approval, at our 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 your death, 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
1	$84.47	11	$8.86	21	$5.32
2	42.86	12	8.24	22	5.15
3	28.99	13	7.71	23	4.99
4	22.06	14	7.26	24	4.84
5	17.91	15	6.87	25	4.71
6	15.14	16	6.53	26	4.59
7	13.16	17	6.23	27	4.47
8	11.68	18	5.96	28	4.37
9	10.53	19	5.73	29	4.27
10	9.61	20	5.51	30	4.18

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 3% 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 3% 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) you become totally disabled prior to age 60;
(2) the Total Disability begins while you are insured;
(3) the Total Disability begins while the Policy is in force;
(4) the Total Disability lasts for at least 6 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 Policyholder is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask you to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. You may be required to be examined by a Physician approved by us as part of the proof. We will not require you 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 your life 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 you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

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

(1) the date you no longer meet the definition of Total Disability; or
(2) the date you refuse to be examined; or
(3) the date you fail to furnish the required proof of Total Disability; or
(4) the date you become age 70; or
(5) the date you retire.

You may use the conversion privilege when this extension ceases. Please refer to the Notice of Conversion found on the Conversion Privilege page for rules and requirements. You are not entitled to conversion if you return to work and are again eligible for the insurance

under the Policy. If you use 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 30 days after the loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Office or to our authorized agent. The notice should include the Policyholder's name, the Policy number and your name.

CLAIM FORMS: When we receive the notice of claim, we will send the claimant the forms to file the proof of loss. If we do not send them within 15 days after we receive notice, then the proof of loss requirements will be met by giving us a written statement of the nature and extent of the loss within 90 days after the loss began.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 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 you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

First Reliance Standard Life shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have you 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 the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years from the time written proof of loss is received.

FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION

We will allow your coverage to continue for up to 12 weeks in a 12 month period, if you are eligible for, and the Policyholder has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 for any of the following reasons:

(1) To provide care after the birth of a son or daughter; or
(2) To provide care for a son or daughter upon legal adoption; or
(3) To provide care after the placement of a foster child in your home; or
(4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
(5) To take care of your own serious health condition as explained below.

If you, due to your own serious health condition, meet the definition of Total Disability in the Policy, you will be considered Totally Disabled and eligible for Waiver of Premium benefits according to the Waiver of Premium in Event of Total Disability provision. If you, due to your own serious health condition, are on a Family and Medical Leave of Absence, but not eligible for Waiver of Premium benefits under the Policy, insurance coverage will be continued under this extension.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Policyholder, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical Leave Act of 1993. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave began; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If you are granted a Family and Medical Leave of Absence, the following applies to you:

(1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.

(2) Coverage will terminate for you if you do not return to work as scheduled according to the terms of your agreement with the Policyholder; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will coverage be extended under this benefit beyond 12 weeks in a 12 month

period. Insurance will not be terminated for you if you become Totally Disabled during the period of the leave and are eligible for Waiver of Premium benefits, if any, according to the terms of the Policy.

(3) This extension is not available if you convert your coverage under the Conversion Privilege.

(4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively at Work in all instances unless such leave is due to your own illness, injury, or disability. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you while you are not Actively at Work until you have returned to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

MILITARY SERVICES LEAVE OF ABSENCE COVERAGE

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you enter the military service of the United States. While you are on a Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective for you until you have returned to Active work for one full day. All other terms and conditions of the Policy will remain in force during this continuation period. Your continued coverage will cease on the earliest of the following dates:

(1) the date the Policy terminates; or
(2) the date ending the last period for which any required premium was paid; or
(3) twelve (12) weeks from the date your continued coverage began.

If coverage is terminated or reduces, you may convert such coverage in accordance with the Conversion Privilege. Please see the Conversion Privilege for the rules governing conversion rights.

The Policy, however, does not cover any loss which occurs while you are on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared).

GROUP TERM LIFE INSURANCE ACCELERATED BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR. ONLY THE INSURED HAS THE RIGHT TO THE ACCELERATED BENEFIT.

Attached to Group Policy Number: GL 131452
Issued to Group Policyholder: Legal Services for New York City

This Rider is attached to and made a part of the Policy shown above. Your Certificate is hereby amended, in consideration of the application for this Rider, by the addition of the following benefit. In this Rider, First 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 Certificate at death of the Insured. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Accelerated Benefit Rider.

"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 less than 12 months.

"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, while insured, he 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.

AMOUNT OF THE ACCELERATED BENEFIT: The Accelerated Benefit will be an amount equal to 50% 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 $250,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. If we agree to installment payments, we will make four quarterly payments. Each payment will equal 25% of the total Accelerated Benefit.Once the Accelerated Benefit has been paid for any Insured under this Rider, no additional Accelerated Benefit is payable under this Rider for that Insured.

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 an 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 by an amount equal to the Accelerated Benefit paid to the Insured, as will the maximum Face Amount available under the Conversion Privilege. After this reduction as a result of payment of the Accelerated Benefit, any subsequent changes in the amount of insurance are subject to the Conversion Privilege as stated in the Policy to which this Rider is attached.

The payment of the Accelerated Benefit will have no effect on the premium payment requirements of the Policy.

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 herewith.

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

Secretary

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

CERTIFICATE OF INSURANCE

POLICYHOLDER: Legal Services for New York City

GROUP POLICY NUMBER: VAR 201591

POLICY EFFECTIVE DATE: January 1, 2002, as amended in the Policy through January 1, 2007

Subject to the terms of the Group Policy, we certify that you are insured for the benefits which apply to your class as described on the Schedule of Benefits, provided you are an Insured Person, as defined. The Group Policy Number, Policyholder, and Policy Effective Date are listed above.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all Certificates that may have been issued to you earlier.

This Certificate is signed by our President and Secretary.

Secretary

President

GROUP ACCIDENT CERTIFICATE

This Group Accident Certificate amends the previous Group Accident Certificates and is dated April 17, 2007.

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SCHEDULE OF BENEFITS

ELIGIBILITY: Each active Full-time and Part-time employee, except an employee included in any other class and any person employed on a temporary or seasonal basis.

INDIVIDUAL EFFECTIVE DATE: The day you become eligible.

AMOUNT OF INSURANCE: PRINCIPAL SUM:

INSURED PERSONS:

One and one-half (1.5) times Earnings, rounded to the next higher $1,000, subject to a maximum of $225,000.

The Amount of Principal Sum will be: (1) reduced to 65% of the pre-age 70 amount at age 70; (2) further reduced to 45% of the pre-age 70 amount at age 75; (3) further reduced to 30% of the pre-age 70 amount at age 80 and (4) further reduced to 15% of the pre-age 70 amount at age 85.

Insurance terminates at your Retirement.

CHANGES IN AMOUNT OF INSURANCE: Changes in the Amount of Insurance because of a change in age, class or Earnings (if applicable) are effective on the date of the change, provided that if you are not Actively at Work on the date an increase would otherwise take effect for you, such increase will not take effect until the date you return to active work.

CONTRIBUTIONS: You are not required to contribute toward the cost of your insurance coverage.

DEFINITIONS

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

"Earnings" means the basic annual wages received from the Policyholder on the day just before the date of the Injury, prior to any deductions to a 401(k) plan. Earnings do not include commissions, overtime pay, bonuses or any other special compensation not received as basic wages.

If hourly employees are insured, the number of hours worked during a regularly scheduled work week, not to exceed 40 hours per week, times 52 weeks, will be used to determine annual Earnings.

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

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

"Insured Person" means a person who meets the Eligibility requirements of the Policy and is enrolled for this insurance, and whose insurance under the Policy is in effect.

"Insured" means an Insured Person unless the context indicates otherwise.

"Injury" means accidental bodily injury or accidental exposure sustained by an Insured which is caused directly and independently of all other causes occurring while the Insured's coverage under the Policy is in force and which results in a covered loss within 365 days of said accidental Injury.

"Part-time" means working for the Policyholder for a minimum of 20 hours during a person's regularly scheduled work week.

"Policyholder", shall also include an associated or affiliated company, when referring to premium payments; Active Work; Full-time or Part-time work; or Earnings.

"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 the Policyholder;
(2) retirement pension benefits under any plan which the Policyholder sponsors, or to which the Policyholder makes or has made contributions; and/or
(3) retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act, while you are receiving retirement pension benefits from the Policyholder.

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

"You", "your", and "yours" means the Insured Person.

GENERAL PROVISIONS

CHANGES: No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to the Policy.

INCONTESTABILITY: Any statements made by the Policyholder, any Insured Person, or on behalf of any Insured Person 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 you, or on your behalf; and
   (b) a copy of such written instrument is or has been furnished to you, or your beneficiary or legal representative.

(2) If the statement relates to your 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 your lifetime.

ASSIGNMENT: Ownership of any benefit provided under the 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.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, 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.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

MISSTATEMENT OF AGE: If an Insured's age has been misstated, benefits will be those that apply to his correct age.

NOT IN LIEU OF WORKER'S COMPENSATION: The Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

PRONOUNS: All pronouns include either gender unless the context indicates otherwise.

INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the Individual Effective Date as shown on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date as shown on the Schedule of Benefits; or

(2) on the first day of the month coincident with or next following the date you apply.

If you are not Actively At Work on the day your insurance is to go into effect, your insurance will go into effect on the day you return to Active Work for one full day.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

TERMINATION OF INDIVIDUAL INSURANCE: Your coverage will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for your coverage.

Any covered Injury which occurs prior to the termination of this insurance coverage will not be affected if it results in a covered loss within 365 days of the injury regardless of whether the Policy or your coverage remains in effect after such injury.

CONTINUATION OF INDIVIDUAL INSURANCE: Your coverage may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

(1) 12 months, if you cease to be eligible due to illness or Injury; or

(2) 1 month, if you cease to be eligible due to temporary lay-off or approved leave of absence.

CONVERSION PRIVILEGE

You can use this privilege when your Accidental Death and Dismemberment insurance coverage is no longer in force for any reason, except termination of the group Policy. Written application for the converted policy must be made within 31 days after coverage ends. The first premium must also be paid within that time. The issuance of the converted policy is subject to the following conditions:

(1) the converted policy will take effect on the date of the termination of this insurance, or on the date of application for the converted policy, whichever is later;

(2) proof of health will not be required; and

(3) the premium will be applicable to the class of risk to which the Insured belongs, at his attained age, and to the form and amount of insurance provided.

The converted policy's Principal Sum will be the lower of:

(1) the Amount of Principal Sum applicable to the Insured under the Policy; or

(2) $250,000.

The converted policy may provide that it will be renewable on any anniversary with our consent, subject to a maximum age limit.

The converted policy may exclude any condition or hazard which applied to the Insured at the time coverage terminated. Benefits will not be paid under the converted policy for a claim originating under the Policy.

The Insured may convert to any individual Accidental Death and Dismemberment policy we offer in the state where he lives.

BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Policyholder, or if none, to the beneficiary named to receive the proceeds of the basic Group Life policy issued to the Policyholder. Benefits will not be paid to the Policyholder or an officer of the Policyholder. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his 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 in another provision of this Certificate.

If you have not named a beneficiary, or an Insured's 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 children (including legally adopted children), 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.

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.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

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

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 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 and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 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 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible.

We will presume you suffered loss of life due to any Injury, if:

(1) while covered under the Policy you were riding in a conveyance that was involved in an accident, not excluded from coverage;
(2) the conveyance is wrecked, sinks, or disappears as a result of such accident; and
(3) your body is not found within 1 year of the accident.

TIME PAYMENT OF CLAIMS: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

PAYMENT OF CLAIMS: If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

First Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have

a doctor of our choice examine the Insured as often as we think necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to make an autopsy in case of death, unless the law forbids it. We will pay for the cost of both the examination and the autopsy.

LEGAL ACTION: No lawsuit or action in equity can be brought to recover on the Policy:

(1) before 60 days following the date written proof of loss was furnished to us; or
(2) after 3 years following the date written proof of loss is required.

SETTLEMENT OPTIONS

You may elect a single sum payment or a different way in which the beneficiary will receive payment of the Principal Sum. If other than a single sum payment is desired, you 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 each are not allowed.

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

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 beneficiary's estate, unless otherwise agreed to in the instructions for settlement.

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

COVERAGE FOR MEMBERS OF RESERVE-NATIONAL GUARD

DESCRIPTION OF COVERAGE: We will pay plan benefits for a loss due to Injury of any Insured which is sustained while such Insured is a member of an organized Reserve Corps or National Guard Unit and is:

(1) attending any regularly scheduled or routine training of less than 60 days, or is enroute to or from such training;

(2) attending a Service School no matter how long it is, or is enroute to or from that school;

(3) taking part in any authorized inactive duty training; or

(4) taking part as a unit member in a parade or exhibition authorized by official orders.

No benefit is payable for any loss that occurs during active duty.

DEFINITION:

"Service School" means one operated by or on behalf of the United States of America.

SEAT BELT AND AIR BAG BENEFIT

DESCRIPTION OF COVERAGE: We will pay a sum equal to 10% of the Insured Person's Principal Sum if:

(1) the Insured Person dies as the result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;

(2) a police report establishes that the Insured Person was properly strapped in a Seat Belt at the time;

(3) Loss of Life benefits are payable for the Insured Person's death hereunder.

We will pay an additional 5% if the Insured Person is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System. The Insured Person must be positioned in a seat which is designed to be protected by an air bag and must be properly strapped in the Seat Belt when the air bag inflates. In addition to the above requirements, the police report must establish that the air bag inflated properly upon impact.

The total maximum benefit payable is $100,000.00.

No benefit will be paid for any loss sustained:

(1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving; or

(2) if the Insured Person is not wearing a Seat Belt for any reason; or

(3) while the Insured Person is sharing a Seat Belt; or

(4) due to a defect in the Supplemental Restraint System's diagnostic system.

If the police report does not clearly establish that the Insured Person was or was not wearing a Seat Belt at the time of the accident causing the Insured Person's death, we will pay a sum equal to $1,000 in lieu of the benefit described above.

DEFINITIONS:

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint.

An air bag is not considered a Seat Belt.

"Supplemental Restraint System" means an air bag which inflates for added protection to the head and chest areas.

"Four-Wheel Vehicle" means a vehicle listed below provided it is: duly licensed for passenger use; and designated primarily for use on public streets and highways:

(1) a private passenger automobile; or

(2) a station wagon; or

(3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or

(4) a self-propelled motor home.

ACCIDENTAL DEATH AND DISMEMBERMENT AND TOTAL LOSS OF USE BENEFIT

DESCRIPTION OF COVERAGE

LOSS OF LIFE, LIMB, SIGHT, SPEECH OR HEARING AND TOTAL LOSS OF USE: If, due to Injury, an Insured Person suffers any one of the following specific Losses within 365 days from the date of the accident we will pay the Benefit Amount listed below. In order to be eligible for benefits for Total Loss of Use of limbs such loss must continue for a period of 12 consecutive months after the onset and must be shown by proper medical authority at the end of such 12 months that Total Loss of Use has been continuous and will be permanent. However, if more than one listed loss results from any one accident, we will only pay the one largest applicable benefit as listed below. In no event will the total of all benefits paid for any one Insured Person for any one accident under this benefit, exceed that Insured Person's Principal Sum.

LOSS	**BENEFIT AMOUNT:**
Loss of Life	100% of the Insured Person's Principal Sum
Loss of Two or More Members	100% of the Insured Person's Principal Sum
Loss of Speech and Hearing	100% of the Insured Person's Principal Sum
Loss of One Member	50% of the Insured Person's Principal Sum
Loss of Speech or Hearing	50% of the Insured Person's Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Insured Person's Principal Sum

For Total Loss of Use of:	**Benefit Amount:**
Both Arms and Both Legs	100% of the Insured Person's Principal Sum
Both Arms	67% of the Insured Person's Principal Sum
Both Legs	67% of the Insured Person's Principal Sum
One Arm and One Leg	67% of the Insured Person's Principal Sum
Both Arms and One Leg or Both Legs and One Arm	75% of the Insured Person's Principal Sum
One Arm or One Leg	50% of the Insured Person's Principal Sum

DEFINITIONS:
"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

(1) a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;

(2) an eye, Loss means the total and irrecoverable loss of sight;

(3) speech, Loss means the total and irrecoverable loss of the function;

(4) hearing, Loss means the total and irrecoverable loss of the hearing in both ears;

(5) a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.

"Total Loss of Use" means loss of the ability to function because of:

(1) incurable paralysis;

(2) atrophy; or

(3) an arthritic condition resulting directly and independently of all other causes from an Injury.

In addition "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.

COMMON CARRIER BENEFIT

DESCRIPTION OF COVERAGE: We will pay an additional benefit equal to the amount paid under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if:

(1) an Insured Person sustains such a loss due to Injury; and

(2) such Injury occurs while the Insured Person is riding as a passenger (not as an operator or crew member) in a Common Carrier.

DEFINITION:

"Common Carrier" means any:

(1) aircraft operated under a license for hire for the transportation of passengers;

(2) transport aircraft operated by the Military Aircraft Command (MAC) of the United States or by the similar air transport service of any country; or

(3) land or water conveyance licensed for hire for the transportation of passengers.

FAMILY AND MEDICAL LEAVE OF ABSENCE EXTENSION

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you are eligible for, and the Policyholder has approved, a Family and Medical Leave of Absence under the terms of the Family and Medical Leave Act of 1993 for any of the following reasons:

(1) To provide care after the birth of a son or daughter; or
(2) To provide care for a son or daughter upon legal adoption; or
(3) To provide care after the placement of a foster child in your home; or
(4) To provide care to a spouse, son, daughter, or parent due to serious illness; or
(5) To take care of your own serious health condition.

You will not qualify for the Family and Medical Leave of Absence Extension unless we have received proof from the Policyholder, in a form satisfactory to us, that you have been granted a leave under the terms of the Family and Medical leave Act of 1993. Such proof: (1) must outline the terms of your leave; and (2) give the date the leave is to begin; and (3) the date it is expected to end; and (4) must be received by us within thirty-one (31) days after a claim for benefits has been filed with us.

If you are granted a Family and Medical Leave of Absence, the following applies to you:

(1) While you are on an approved Family and Medical Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force.

(2) Coverage will terminate for you if you do not return to work as scheduled according to the terms of your agreement with the Policyholder; however, you are eligible to convert your coverage under the Conversion Privilege. In no case will coverage be extended under this benefit beyond twelve (12) weeks in a twelve (12) month period. Insurance will not be terminated for an Insured who becomes Totally Disabled during the period of the leave and who is eligible for benefits according to the terms of the Policy.

(3) This extension is not available if you convert your coverage under the Conversion Privilege.

(4) While you are on an approved Family and Medical Leave of Absence, you will be considered Actively At Work in all instances unless such leave is due to your own illness, injury or disability. Changes such as revisions to coverage because of age, class, or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective if you are not Actively at Work until such time as you return to Active Work for one full day.

All other terms and conditions of the Policy will remain in force while you are on an approved Family and Medical Leave of Absence.

MILITARY SERVICES LEAVE OF ABSENCE COVERAGE

We will allow your coverage to continue for up to twelve (12) weeks in a twelve (12) month period, if you enter the military service of the United States. While you are on Military Services Leave of Absence, the required premium must be paid according to the terms specified in the Policy to keep the insurance in force. Changes such as revisions to coverage because of age, class or salary changes will apply during the leave except that increases in amount of insurance, whether automatic or subject to election, are not effective until you have returned to work from a Military Services Leave of Absence for one full day. All other terms and conditions of the Policy will remain in force during the continuation period. Your continued coverage will cease on the earliest of the following dates:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for your coverage; or
(3) twelve (12) weeks from the date your continued coverage began.

The Policy, however, does not cover any loss which occurs on active duty in the military service if such loss is caused by or arises out of such military service, including but not limited to war or act of war (whether declared or undeclared) and is also subject to any other exclusions listed in the Exclusions provision.

EXCLUSIONS

The Policy does not cover any loss:

(1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(2) caused by suicide, or intentionally self-inflicted injuries; or

(3) caused by or resulting from war or any act of war, declared or undeclared; or

(4) caused by an accident that occurs while in the armed forces of any country, except when participating in the Reserve or National Guard on inactive duty status in such activities as attending regularly scheduled or routine training, attending Service School, taking part in any other authorized inactive duty training, parade, or exhibition, as well as traveling to and from such activity. (Any premium paid to us for any period not covered by this Policy while the Insured is in such service will be returned pro rata); or

(5) caused by or resulting from riding in, getting into or out of any aircraft, unless:

(a) the Insured Person is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
(b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured Person, or any other employer of the Insured Person, unless a specific written agreement has been obtained from us; or

(6) sustained during the Insured Person's commission or attempted commission of a felony; or

(7) caused by the Insured Person's alcoholism; or

(8) caused by the Insured Person's drug addiction.

SUMMARY PLAN DESCRIPTION

The following section entitled Summary Plan Description was prepared by First Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. First Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

SUMMARY PLAN DESCRIPTION

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

PLAN NAME:	Group Life and Accidental Death and Dismemberment Insurance
PLAN SPONSOR:	Legal Services for New York City 350 Broadway New York, NY 10013-0000 (212) 431-7200
SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:	13-2600199
GL PLAN NUMBER:	501
VAR PLAN NUMBER:	Not Applicable
TYPE OF PLAN:	Death and Dismemberment Benefit Plan
PLAN BENEFITS:	Fully Insured - Group Life, Accidental Death and Dismemberment Insurance Benefits
TYPE OF ADMINISTRATION:	The plan is administered in accordance with the terms of the Group Policy issued by the First Reliance Standard Life Insurance Company, 590 Madison Avenue, 29th Floor, New York, NY 10022.
PLAN ADMINISTRATOR:	The Plan Sponsor named above.

AGENT FOR SERVICE OF LEGAL PROCESS:	The Plan Sponsor named above.
GL PLAN YEAR:	The plan's fiscal records are kept on a calendar year basis beginning January 1st.
PLAN COSTS:	The cost of the benefits provided under the plan are paid for by the employer.
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS:	A plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.
AMENDMENT AND TERMINATION:	The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.

CLAIM PROCEDURES FOR CLAIMS FILED WITH FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

First Reliance Standard Life Insurance Company
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-353-3986.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate that the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

Disability Benefit Claims

In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for

the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

First Reliance Standard Life Insurance Company
Quality Review Unit
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532

Non-Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims

1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and

other information relevant to the claimant's claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and
8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information

necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims

A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency" (where applicable).

DEFINITIONS

The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term “us” or “our” refers to First Reliance Standard Life Insurance Company.

The term “relevant” means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The term “First Reliance Standard Life Insurance Company” means First Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. 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 Benefits 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 benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests 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 benefit or exercising your rights under ERISA.

First Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Enforce Your Rights

If your claim for a 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 the 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 part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits 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 Benefits Security Administration.

FIRST RELIANCE STANDARD
Life Insurance Company

a DELPHI company

Home Office: New York, New York

GL 131452
VAR 201591
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