

Group Accidental Death and Dismemberment (AD&D) Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098



Effective: January 1, 2016

POLICYHOLDER: inVentiv Health Inc.

POLICY NUMBER: 70081

Read Your Certificate Carefully

If you meet the eligibility and enrollment requirements herein, you are insured under the group policy shown on the specifications page. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Legal Actions

No legal action may be brought to recover on this certificate within the first sixty days after written proof of loss has been given as required by this certificate. No such action may be brought after three years from the time written proof of loss is required to be given.

Secretary

President

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GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CERTIFICATE OF INSURANCE

GENERAL INFORMATION

POLICYHOLDER: inVentiv Health Inc.

POLICY NUMBER: 70081

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in **Massachusetts**.

POLICY EFFECTIVE DATE: January 1, 2016.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

GROUP: The group is composed of all active employees of the policyholder and its associated companies working in the United States and designated expatriates on United States payroll in the following classes:

- Class 1 All active full-time employees, excluding Clinical Consultants
- Class 2 All active full-time employees classified as Clinical Consultants
- Class 3 Employees on file with the policyholder as reported to Securian Life

NO DOUBLE COVERAGE: A person cannot be covered under more than one class. A person cannot be covered as both an active employee and a retiree. Any person who is eligible as an employee or retiree under the policy, or insured under the portability provisions, is not eligible as a dependent. Only one person can insure an eligible dependent child.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIRED: 30 hours per week

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE:

<u>Eligible Class</u>	<u>Amount of AD&D Insurance</u>
Class 1	An amount elected by the employee, in increments of \$10,000, to a maximum of \$500,000 and in increments of \$50,000 from \$500,000 to maximum of \$1,000,000. Subject to a minimum of \$10,000 and a maximum of the lesser of 10 times an employee's annual earnings or \$1,000,000.
Class 2	None
Class 3	Amounts on file with the policyholder as reported to Securian Life.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

AGE REDUCTIONS:

The amount of insurance on an employee age 65 or older shall be a percentage of the amount otherwise provided by the plan of insurance applicable to such employee in accordance with the following table:

<u>Age of Employee</u>	<u>Amount of Insurance</u>
65 - 69	65%
70 and over	50%

Age reductions will apply the first day of the month following an insured employee's 65th and 70th birthdays.

RETIREMENT REDUCTIONS:

All insurance terminates at retirement.

CONTRIBUTORY/NONCONTRIBUTORY:

All AD&D insurance is contributory insurance.

INCREASES AND DECREASES:

The effective date of increases and decreases due to a change in eligible class or earnings is the date of the change in eligible class or earnings. All increases are subject to the actively at work requirement.

Requests for increases and decreases may be made only at annual enrollment or within 31 days of a qualified status change (as defined by the employer). Requests made due to a status change shall be effective on the date of the request. Requests made during an annual enrollment shall be effective on the general effective date of the annual enrollment. All increases are subject to the actively at work requirement.

Definitions

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

contributory insurance

Insurance for which the employee is required to make premium contributions.

earnings

An employee's basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated company.

insured

A person who is eligible for and becomes insured under the terms of this certificate.

licensed physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. The physician cannot be you or your spouse, children, parents, grandparents, grandchildren, brothers or sisters, or the spouse of any such individuals.

non-work day

A day on which the employee is not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long-term disability.

noncontributory insurance

Insurance for which the employee is not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. You are not eligible to become insured until the first day following the waiting period. Any such waiting period is shown on the specifications page.

we, our, us

Securian Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

If you meet the eligibility and enrollment requirements, you are insured under the group policy shown on the specifications page. Your application as defined under this certificate is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will, in the absence of fraud, be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

What employees are eligible for Accidental Death and Dismemberment (AD&D) insurance?

An employee is eligible for AD&D insurance if he or she:

- (1) is a member of the eligible group and of an eligible class identified in the group policy; and
- (2) works for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page; and
- (3) has satisfied the waiting period, if any; and

- (4) meets the actively at work requirement described in the “What is the actively at work requirement?” provision of this section.

Are employees of associated companies eligible for insurance under the group policy?

Yes. Employees of associated companies may be eligible for insurance under the group policy. The policyholder represents any associated company in all transactions pertaining to the group policy. The policyholder’s acts or omissions and every notice given by us to the policyholder shall be binding on every associated company. When an associated company ceases its participation under the policy, the policy shall be considered to be terminated for all employees of the associated company. All provisions related to the policy terminating will apply to such employees.

Are retired employees eligible for insurance?

If the policyholder’s plan of insurance, as shown on the specifications page, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor to have his or her insurance continued. If the policyholder’s plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, an employee must be actively at work performing his or her customary duties at the employer’s normal place of business, or at other places the employer’s business requires him or her to travel.

Employees not working due to illness or injury do not meet the actively at work requirement nor do employees receiving sick pay, short-term disability benefits or long-term disability benefits.

If the employee is not actively at work on the date coverage would otherwise begin, or on the date an increase in his or her amount of insurance would otherwise be effective, he or she will not be eligible for the coverage or increase until he or she returns to active work. However, if the absence is on a non-work day, coverage will not be delayed provided the employee was actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, an employee is eligible to continue to be insured only while he or she remains actively at work.

Any insurance or increase in insurance which is elected or put in force while you are not actively at work will not be eligible for claim payment. You or your beneficiary will receive a refund of premium for any contributory insurance for which you were not eligible.

What is the delayed effective date provision for dependents?

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before your insurance is effective.

When does your insurance become effective?

Your insurance becomes effective on the date that all of the following conditions have been met:

- (1) you meet all eligibility requirements; and
- (2) for contributory coverage, you apply for coverage in accordance with the application methods agreed upon by the policyholder and us.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may be continued on an insured employee who is not actively at work due to sickness, injury, leave of absence or temporary layoff, subject to the employer’s practices and procedures, including the employer’s limits on the length of continuation allowed for the type of absence. Continuation is contingent upon continued premium payment and is subject to the following maximum time frames:

- (1) if you are on non-medical leave of absence or temporary layoff, insurance cannot be continued beyond 90 days from the last day you were actively at work.
- (2) if you are on a medical leave of absence, insurance cannot be continued beyond the later of 12 months from the last day you were actively at work or attained age 65.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. The above limits will be expanded if necessary in order to meet such requirements.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a regular periodic basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the applicable premium rate multiplied by the number of \$1,000 units of insurance in force on the date premiums are due. The premium may

also be computed by any other method on which the policyholder and we agree.

Premium rates are subject to change according to the provisions of the group policy.

Accidental Death and Dismemberment Benefit

What does accidental death or dismemberment by accidental injury mean?

AD&D coverage is limited coverage. This means this coverage will provide benefits only when your loss, death or dismemberment results, directly and independently from all other causes, from an accidental bodily injury which was unintended, unexpected and unforeseen. The bodily injury must be evidenced by a visible contusion or wound, except in the case of accidental drowning. The bodily injury must be the sole cause of your loss, death or dismemberment. The injury and accidental loss, death or dismemberment must occur while your coverage is in force. Your loss, death or dismemberment must occur within 365 days after the date of the accidental injury. In no event will we pay the accidental death or dismemberment benefit where your accident, injury, loss, death or dismemberment is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

- (1) self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
- (2) suicide or attempted suicide, whether sane or insane; or
- (3) your participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
- (4) bodily or mental infirmity, illness or disease; or
- (5) the use of alcohol; or
- (6) the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
- (7) motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
- (8) infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
- (9) medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
- (10) travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier; or
- (11) war or any act of war, whether declared or undeclared.

What is the amount of the AD&D benefit?

The amount of the benefit shall be a percentage of the amount of insurance shown on the specifications page. The percentage is determined by the type of loss as shown in the following table:

TYPE OF LOSS	PERCENT OF AMOUNT OF INSURANCE
Life	100%
Both Hands or Both Feet.....	100%
Sight of Both Eyes.....	100%
Speech and Hearing in Both Ears.....	100%
One Hand and One Foot.....	100%
One Foot and Sight of One Eye.....	100%
One Hand and Sight of One Eye.....	100%
Quadriplegia.....	100%
Paraplegia.....	75%
Sight of One Eye.....	50%
Speech or Hearing in Both Ears.....	50%
One Hand or One Foot.....	50%
Hemiplegia.....	50%
All Four Fingers of One Hand.....	50%
Thumb and Index Finger of One Hand.....	25%
Uniplegia.....	25%
Loss of all the Toes on One Foot.....	20%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb or finger means complete severance at or above the metacarpophalangeal joints. Loss of toes means the complete severance at or above the metatarsalphalangeal joints.

Quadriplegia means total and permanent paralysis of both upper limbs (from the shoulder down including total paralysis of both hands) and both lower limbs (from the waist down including total paralysis of both feet). Paraplegia means total and permanent paralysis of both lower limbs (from the waist down including total paralysis of both feet). Hemiplegia means total and permanent paralysis of both the upper limb (from the shoulder down including total paralysis of the hand) and lower limb (from the waist down including total paralysis of the foot) on one side of the body. Uniplegia means total and permanent paralysis of one limb (from the shoulder down including total paralysis of the hand if claiming an upper limb and from the waist down including total paralysis of the foot if claiming a lower limb).

A benefit is not payable for both loss of one hand and the loss of thumb and index finger of one hand or the loss of four fingers of one hand for injury to the same hand or the loss of one foot and the loss of all toes of one foot as a result of any one accident (the largest benefit of these overlapping losses only will be paid). Under no circumstance will more than one payment be made for the loss or paralysis of the same limb, eye, finger, thumb, toe, hand, foot, sight, speech, or hearing if one payment has already been made for that loss.

Benefits may be paid for more than one accidental loss but the total amount of AD&D insurance payable under this certificate for any one accident, not including any amount paid according to the terms of the Additional Benefits section of this certificate, will never exceed the full amount of the insured's AD&D insurance.

Can you request a change in the amount of your contributory insurance?

Yes. The specifications page describes when changes can be requested, when evidence of insurability will be required for such changes, and when the changes will become effective.

What are the notice of claim and proof of loss requirements?

Written notice of injury on which a claim may be based must be given to us within 30 days after the accident. Proof of loss must be furnished to us within 90 days after the date of loss. However, failure to give such notice and proof within the time provided will not invalidate the claim if it is shown that notice and proof were given as soon as reasonably possible.

When we receive written notice of claim, we will send the claimant our claim forms if he or she needs them. If the claimant does not receive the forms within 15 days, we will accept his or her written description as proof of loss.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit upon receipt at our home office of written proof satisfactory to us as to both substance and form that you died or suffered a covered dismemberment as a result of a covered accidental injury. All payments by us are payable from our home office. The benefit will be paid in a single sum.

To whom will we pay the accidental death or dismemberment benefit?

In the case of your accidental death, we will pay the accidental death benefit to the beneficiary or beneficiaries. All other benefits, including any accidental death or dismemberment payable due to a dependent's loss, will be payable to you, if living, otherwise to your estate.

You name a beneficiary to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You can change the beneficiary designation at any time, provided all of the following are true:

- (1) your coverage is in force; and
- (1) we have written consent of all irrevocable beneficiaries; and
- (2) you have not assigned the ownership of your insurance.

A beneficiary designation must be made in writing or by any other method made available under the plan. Any

beneficiary designation shall take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving the designation.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in your beneficiary designation. To receive the death benefit, a beneficiary must be living at the time of your death. In the event a beneficiary is not living at the time of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

- (1) your lawful spouse if living; otherwise
- (2) your natural or legally adopted child (children) in equal shares, if living; otherwise
- (3) your parents in equal shares, if living; otherwise
- (4) your natural or legally adopted siblings in equal shares, if living; otherwise
- (5) the personal representative of your estate.

Additional Benefits

Unless stated otherwise, additional benefits are payable to the same person or persons who receive the AD&D benefits. Additional benefits are paid in addition to any AD&D benefits described in the Accidental Death and Dismemberment section, unless otherwise stated. All provisions of this certificate, including but not limited to the exclusions and requirements listed under the "What does accidental death or dismemberment by accidental injury mean?" section, shall apply to these additional benefits.

Air Bag Benefit

What is the air bag benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while he or she is driving or riding in a private passenger car, we will pay an additional AD&D benefit equal to the lesser of \$5,000 or 5% of the insured's amount of AD&D insurance.

In order to be eligible for this benefit, the following must apply:

- (1) the seat in which the insured was seated was equipped with a properly installed airbag at the time of the accident; and
- (2) the private passenger car is equipped with seatbelts; and
- (3) a seatbelt was in proper use by the insured at the time of the accident as certified* in the official accident report or by the investigating officer; and

- (4) at the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Airbag means a passive restraint device in a vehicle which inflates upon collision to protect an individual from injury or death.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

*If such certification is unclear whether the insured was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed airbag we will pay a default benefit of \$1,000.

Child Care Benefit

What is the child care benefit?

If you die as a result of a covered accident and you are survived by one or more insured dependent children under age 13, we will pay additional benefits to reimburse for child care expenses incurred for your dependent children while under age 13.

The benefit for each child per year will be the lesser of:

- (1) 3% of your amount of AD&D insurance; or
- (2) \$3,000; or
- (3) actual incurred child care expenses.

Child care expenses are those expenses which are for a service or supply furnished by a licensed child care provider or facility for a dependent child's care. No payment will be made for expenses incurred more than six years after the date of your death or for expenses incurred for dependent children over age 13. Proof of incurred child care expenses shall be required before any benefit payment is made. The child care benefit will be paid to the surviving parent, to the child's guardian, the custodian under the Uniform Transfers to Minors Act or to an adult caretaker when permitted under state law.

Coma Benefit

What is the coma benefit?

If an insured lapses into a coma as a result of and within 365 days of a covered accidental injury, and such coma has lasted for a minimum of 31 days, we will pay a monthly benefit equal to the lesser of:

- (1) 1% of the insured's amount of AD&D insurance; or

- (2) 1% of the difference between the insured's amount of AD&D insurance and the amount of any benefits paid under the loss schedule for the same accident. (if the full amount of AD&D insurance has been paid, no benefit is payable under this section).

This benefit will be paid monthly until the earliest of the following:

- (1) the date the insured recovers such that he or she is no longer in a coma as defined herein; or
- (2) the date of the insured's death. If an accidental death payment is due under this certificate, the amount of such payment will be reduced by the amount of AD&D insurance paid under this coma provision; or
- (3) 12 monthly benefits have been paid. The 12th month will be a lump sum equal to 100% of the amount of AD&D insurance minus the amount already paid under this coma provision.

Coma means a state of profound unconsciousness with no evidence of appropriate responses to stimulation. The insured must be confined in a medical facility and diagnosed as comatose by a licensed physician.

Dependent Child Education Benefit

What is the dependent child education benefit?

We will pay an education benefit on behalf of your dependent children if you die as a result of a covered accident and are survived by one or more insured dependent children, provided that:

- (1) at the time of your death, the dependent child is enrolled as a full-time student at an accredited post-secondary educational institution (however, no benefit will be payable for the current school year); or
- (2) the dependent child enrolls on a full-time basis in an accredited post-secondary educational institution within one year of your death.

The benefit payable will be the lesser of:

- (1) the actual tuition charged, exclusive of room and board; or
- (2) 3% of your amount of insurance; or
- (3) \$3,000.

The benefit will be payable at the beginning of each school year for a maximum of four consecutive years, but not beyond the date the child attains age 25. The benefit will be paid to the insured dependent child if he or she is of legal age. If the insured dependent child is not of legal age the benefit will be paid to the person who provides proof they have paid or will pay the tuition bill for that school year. Proof of enrollment and tuition costs are required for each school year.

Disappearance Benefit

What is the disappearance benefit?

If an insured's body has not been found after one year from the date the conveyance in which he or she was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed, subject to all other terms of the policy and proof satisfactory to us that the accident occurred and the insured was a passenger on the conveyance, that the insured has died as a result of an accidental injury which was unintended, unexpected and unforeseen. Such death shall be considered a covered loss under this certificate.

Exposure Benefit

What is the exposure benefit?

If an insured suffers a loss under the Type of Loss schedule due to exposure to the elements, it will be covered as if it were due to injury, provided such loss results from unavoidable exposure to the elements by reason of a covered accident.

Seatbelt Benefit

What is the seatbelt benefit?

If an insured dies or suffers a covered dismemberment as a result of a covered accident which occurs while he or she is driving or riding in a private passenger car, we will pay an additional AD&D benefit equal to the lesser of:

- (1) \$10,000; or
- (2) 10% of the insured's amount of AD&D insurance.

In order to be eligible for this benefit, the following must apply:

- (1) the private passenger car was equipped with seatbelts; and
- (2) a seatbelt was in proper use by the insured at the time of the accident as certified* in the official accident report or by the investigating officer; and
- (3) at the time of the accident, the driver of the private passenger car was a licensed driver and was not intoxicated, impaired, or under the influence of alcohol or drugs.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

*If such certification is unclear whether the insured was wearing a seatbelt or positioned in a seat protected by a

properly functioning and properly deployed airbag we will pay a default benefit of \$1,000.

Termination

When does an insured's insurance end?

An insured's insurance ends on the earliest of the following:

- (1) the date the group policy ends; or
- (2) the date the insured no longer meets the eligibility requirements; or
- (3) the date the group policy is amended so the insured is no longer eligible; or
- (4) 31 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
- (5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate; or
- (6) the date the insured attains age 70.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earlier of the following to occur:

- (1) 31 days (the grace period) after the due date of any premiums which are not paid; or
- (2) 31 days after we provide the policyholder with notice of our intent to terminate the group policy.

Additional Information

Do we have the right to obtain independent medical verification?

Yes. After you have provided proof of loss at your expense, we retain the right to have an insured medically examined at our expense whenever a claim is pending.

What if an insured's age has been misstated?

If an insured's age has been misstated, the accidental death or dismemberment benefit payable will be that amount to which the insured is entitled based on his or her correct age.

A premium adjustment will be made to the premium you pay for the insured's noncontributory insurance and to the premium an insured pays for contributory insurance, if any, so that the actual premium required at the insured's correct age is paid. If the insured's correct age is such that no benefit is payable, only a refund of premium will be made for the period the insured was not eligible.

Who is the owner of this coverage?

Unless assigned otherwise, you, the insured employee, are the owner of all coverage provided under your certificate. Only the owner has the right to exercise

ownership rights under the certificate, including but not limited to naming or changing a beneficiary, changing the amount of insurance, assigning any or all ownership rights, and terminating the coverage.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Can a change in ownership for a certificate be requested?

Yes. A change in ownership is a type of assignment. All provisions for assignments apply to ownership changes.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer the group policy, and shall provide access to such records when required for us to administer the policy.

If an administrative or clerical error is made in keeping records on or administering the insurance under the group policy, it will not affect otherwise valid insurance. A clerical or administrative error, however, does not continue insurance which is otherwise stopped, make insurance effective when it should not have been or change the amount of insurance provided by the provisions of the policy and no claim shall be paid on amounts put into effect as a result of a past clerical or administrative error. If an error causes a change in premium payment, a fair adjustment will be made.

Can insurance coverage be contested?

Yes. If an insured dies or sustain a covered loss under this certificate within two years of his or her original effective date of coverage or increase in coverage, we will verify the accuracy of the information provided by the insured during the application process. If we discover a material misrepresentation, the coverage will be rescinded and an otherwise valid claim will be denied. This two year period can be extended for fraud or as otherwise allowed by law.

Any statements the insured makes in his or her application will, in the absence of fraud, be considered representations and not warranties. Also, any statement an insured makes will not be used to void his or her insurance, or defend against a claim, unless the statement is contained in the application.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate or in the group policy is in conflict with the laws of the state governing the group policy or the certificates, the provision will be deemed to be amended to conform to such laws.

What is the policy interpretation right and authority?

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Securian Life has the exclusive right and authority, in its sole discretion, to interpret the group policy and decide all matters arising thereunder. Securian Life's exercise of that authority shall be conclusive and binding on all persons unless it can be shown that the determination was arbitrary and capricious.

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator of your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Together they comprise your Summary Plan Description (SPD).

Summary Plan Description

General Information

Name of Plan	inVentiv Health, Inc. Employee Health Care Program
Plan Sponsor	Name: inVentiv Health, Inc. Address: 500 Atrium Drive, Somerset, NJ 08873
Employer ID	Employer Identification Number (EIN): 52-2181734
Plan Number	Plan Number: 501
Type of Plan	Welfare Plan providing life insurance and associated benefits for employees.
Administration of Plan	The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Securian Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of a plan.
Plan Administrator	inVentiv Health, Inc. ATTENTION: Vice President of Benefits 500 Atrium Drive Somerset, NJ 08873 (732) 537-4845 benefitsgroup@inventivhealth.com
Agent for Service of Legal Process	inVentiv Health, Inc. Employee Health Care Program ATTENTION: Vice President of Benefits 500 Atrium Drive Somerset, NJ 08873 (732) 537-4845 benefitsgroup@inventivhealth.com
Plan Year	January 1 – December 31
Plan Funding	The Plan has an insurance policy(ies) with Securian Life Insurance Company. The premiums for the policy(ies) are paid by employer and employee contributions.
Interpretation, Amendment and Termination	The plan sponsor reserves the right to interpret, change or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained from the Employer.

Contact your Plan Administrator if you have any questions or need claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments when the completed forms are returned. After your claim has been processed by Securian Life, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

During all steps of the claims appeal procedure, you can write or call the appropriate Plan Administrator and ask to see all plan documents affecting your claim. In addition you may have an attorney or other representative write letters or otherwise act on your behalf, but the Plan Administrator reserves the right to require written authorization from you.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, Securian Life will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and it shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for benefits will be provided by Securian Life and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

Disability Claims Only – The following will also be included:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision.
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

C. Appealing the Denial of a Claim

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Securian Life. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days (180 days for any disability claims) after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by Securian Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of the missing information and shall specify a timeframe, no less than 60 days (180 days for disability claims), in which the necessary information must be provided. Where the timeframe to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 60 days (180 days for disability claims) of the date on the notice the Plan will close the appeal and no further consideration will take place.

A decision on appeal is adverse if it is a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the claimant is no longer eligible to participate in a plan.

Written notification of the Plan's decision on a disability or non-disability appeal shall be provided to the claimant and will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent Plan provisions on which the denial was based
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents
- A statement of the right to sue in federal court.

Disability Claims Only

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

D. Legal Action Following Appeals

After completing all mandatory appeal procedures, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed against the Plan after two years from the date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not file a claim for a benefit and seek timely review of a denial of that claim.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay the cost 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.

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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA.

Securian Life Insurance Company • A Stock Company

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GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) CERTIFICATE OF INSURANCE