120 ROYALL STREET, CANTON, MASSACHUSETTS 02021

Group Policy Number: C14951

DOGWOOD STATE BANK
5401 SIX FORKS RD
RALEIGH, NC 27609

Enclosed please find the Master Policy for Boston Mutual's Critical Illness/Specified Disease insurance coverage made available to your employees on a voluntary basis. We congratulate you on your selection.

Eligible employees who apply for this coverage will be issued individual certificates of insurance which reflect the coverage amounts and features included.

Since 1891, Boston Mutual Life Insurance Company has maintained a commitment to providing the timely and efficient service that our customers expect and deserve. If you have any questions regarding this Master Policy, please feel free to call our Client Services team at 1-877-624-2249.

We value the trust and confidence you have placed in Boston Mutual Life Insurance Company.

Very truly yours,

Paul A. Quaranto Jr.
President

IMPORTANT: ALL CLAIMS AND INQUIRIES CONCERNING CLAIMS SHOULD BE SUBMITTED TO:
BOSTON MUTUAL LIFE INSURANCE COMPANY
CLAIM SERVICE CENTER
120 ROYALL STREET
CANTON, MA 02021
TELEPHONE: 1-877-212-2950

120 ROYALL STREET•CANTON, MASSACHUSETTS 02021•TEL. (800) 669-2668 •FAX (781) 770-0521

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

GROUP SPECIFIED DISEASE WITH CANCER MASTER POLICY

Based on the Application for this Group Insurance Policy (herein called the Plan) made by
DOGWOOD STATE BANK
(herein called the Policyholder)
and based on the payment of the premium when due, the Company agrees to pay the benefits provided on the following pages. The Policy is a legal contract between the Policyholder and the Company.

THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

This Policy contains a limitation for Pre-Existing Conditions. Refer to the Limitations and Exclusions provision.

NO RECOVERY FOR PRE-EXISTING DIAGNOSED CANCER – READ CAREFULLY

No benefits will be provided during the first 12 months of the Policy for Cancer diagnosed before the 30th day after the Effective Date shown in the Schedule.

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

The first anniversary of this Plan will be the Anniversary Date shown below. "We", "us", and "our" refer to the Company. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signatures below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in Canton, Massachusetts on the Effective Date.

Signed for the Company at its Home Office

Paul A. Quaranto Jr.
President

Grant David Ward
Secretary

Countersigned by _____
Licensed Resident Agent (if required by your state)

Group Policy Number	C14951		
Effective Date	March 01, 2023	**Anniversary Date**	March 01, 2024
Jurisdiction	North Carolina	**Non-Participating**	

GROUP POLICY PROVISIONS

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Certificateholder as used in this Plan, means a person insured under this Plan who is:

1. an eligible Employee of the Policyholder, or an eligible Spouse of the Employee;
2. engaged in full-time work; and
3. included in the class of Employees eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of the Master Policy.

The Effective Date for a Certificateholder is as follows:

1. A Certificateholder's insurance will be effective on the date shown on the Certificate Schedule provided the Certificateholder is then actively at work.

2. If a Certificateholder is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Certificateholder is first thereafter actively at work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date the Certificateholder's insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.

2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date the Certificateholder's insurance became effective.

3. For a Spouse eligible on or first acquired after the Certificateholder's Effective Date, the Effective Date will be the date we assign after approving the enrollment form for such coverage.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan on the day prior to the date any premium is due by giving 45 days written notice. The Plan will terminate when the number of participating Certificateholders is less than the number mutually agreed upon by the Policyholder and the Company in writing.

In these events, this Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period the Plan is in force.

The Policyholder has the sole responsibility to notify Certificateholders of such termination.

TERMINATION OF A CERTIFICATEHOLDER'S INSURANCE

A Certificateholder's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date he ceases to meet the definition of an Employee as defined in the Plan; or
4. on the date he is no longer a member of the class eligible.

Insurance for an insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;

3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive the Certificateholder's written request to terminate coverage for his or her Spouse.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS
Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums in the Certificate. The rates can be changed annually but not more often than every 6 months. The Company will give the Policyholder written notice 45 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS
The first premiums are due on the Effective Date of this Plan. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in Canton, Massachusetts. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD
This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

REINSTATEMENT
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are the written application of the Policyholder satisfactory to the Company and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

The reinstated policy will provide benefits for an injury after the date of reinstatement and benefits for a Specified Critical Illness diagnosed at least ten (10) days after the date of reinstatement. In all other respects, the Policyholder and the Company will have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereto in connection with the reinstatement.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Certificateholder must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed

by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore, angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the enrollment form or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germanomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Frauman's Syndrome, Cowden Disease, Turcot Syndrome.

Cancer – means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. The following are not considered Cancer for purposes of this policy:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
4. Basal cell carcinoma and squamous cell carcinoma of the skin and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis. If a Pathological Diagnosis or a Clinical Diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

Carcinoma in situ - means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. It also includes Stage 1 Hodgkin's Disease and Stage A Prostate Cancer. Carcinoma in situ does not include basal cell carcinoma, squamous cell carcinoma or melanoma diagnosed as Clark's Level I or II or Breslow less than .75mm. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Carcinoma in situ is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

The "first diagnosis" of Cancer/Carcinoma in situ includes a diagnosis of a recurrence of Cancer/Carcinoma in situ that was previously diagnosed before this Certificate was in force if, after the previous diagnosis and before the date of diagnosis of the recurrence, the Insured is free of any symptoms and treatment of the Cancer/Carcinoma in situ for the 12 consecutive months preceding the Certificate Application Date or any 12 consecutive months thereafter. Treatment does not include Maintenance Drug Therapy or routine follow-up visits or tests to verify that the Cancer/Carcinoma in situ has not returned.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis -** A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

2. **Clinical Diagnosis -** A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
   a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
   b. there is medical evidence to support the diagnosis; and
   c. a Doctor is treating the Insured for Cancer and/or Carcinoma in Situ.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior

and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date the Certificateholder signed the enrollment form for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule - This is page 3 of the certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder - means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday, but not more frequently than annually thereafter.

Children means the Certificateholder's biological children, stepchildren, adopted children, foster children or any child for whom he or she is required by a court or administrative order to provide health coverage.

Doctor or Physician - means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include an Insured or their Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

Employee - means the Insured as shown in the Certificate Schedule.

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that the Insured's Doctor or Physician recommends that he or she begin renal dialysis for End Stage Renal Disease.

Family Member - means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work - means the Certificateholder is spending at least 30 hours per week performing his/her occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

Insured(s) -

1. If Employee coverage is shown in the Certificate Schedule, we insure the Employee.
2. If coverage is for the Spouse of an eligible Certificateholder, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached rider (if applicable). Rider coverage is shown on the Certificate Page.
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the enrollment form, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Loss of Sight, Speech or Hearing- means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Maintenance Drug Therapy – means ongoing hormonal treatment, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer or carcinoma in situ due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than palliative or suppression of a cancer that is still present.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than the Insured or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date the Insured signed the enrollment form and indicated the specific rider(s) for which he/she is applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Skin Cancer – means basal cell carcinoma, squamous cell carcinoma and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm. It is not Skin Cancer if it has metastasized and leads to internal cancer. The date of diagnosis for Skin Cancer is the date the tissue specimen is taken.

Specified Critical Illness - means such Illnesses shown in the Certificate Schedule and as defined in this Plan.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If a Certificateholder dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines. For Cancer or Carcinoma in Situ, Treatment does not include Maintenance Drug Therapy or routine follow-up visits and tests to verify if the Cancer/Carcinoma in Situ has not returned.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months (12 months of no treatment for cancer or carcinoma in situ).

Skin Cancer Benefit

We will pay this benefit if an Insured person is diagnosed with Skin Cancer if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Policy.

This benefit is payable only once during the lifetime of the certificate for each Insured person.

Portability Privilege

When coverage would otherwise terminate under this Plan because an Employee ends employment with the Employer, they may elect to continue coverage. An Employee must have been continuously insured for at least 1 month under this Plan and/or the prior Plan just before the date their employment terminated. The coverage that may be continued is that which the Employee had on the date their employment terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
   a. the Certificateholder failed to pay any required premium;
   b. this Group Policy terminates.
2. To keep the Certificate in force the Certificateholder must:
   a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
   b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
   a. the date the Certificateholder fails to pay any required premium;
   b. the date this Group Policy is terminated.

If a Certificateholder qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Plan contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, the Insured may elect to void the Certificate from the beginning and receive a full refund of premium.

PRIOR HISTORY OF CANCER

No benefits are payable for Cancer or Carcinoma in Situ if the Insured was previously diagnosed with a related Cancer before this Certificate was in force and, after the previous diagnosis, the Insured has not gone 12 months without Treatment before a new diagnosis of Cancer/Carcinoma in situ is made.

PRE-EXISTING CONDITIONS LIMITATION (Not Applicable to Insureds with a Prior History of Cancer or Carcinoma in Situ – See PRIOR HISTORY OF CANCER)

This Plan contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the

Certificate Application Date, no benefits will be payable for that claim. This Pre-Existing Condition limitation does not apply to newborn, adopted or foster Dependent Children.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence. For purposes of this exclusion, war does not include an act of terrorism.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, 120 Royall Street, Canton MA 02021. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, 120 Royall Street, Canton MA 02021 within 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send the Insured written notice of our claim decision within 30 days after we receive due proof of loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send the Insured a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send the Insured written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. The Insured will have 45 days to provide any additional information requested.

If the claim is urgent, we will notify the Insured of our decision within 72 hours. If we need more information, we will let the Insured know within 24 hours of the claim. At that time we will tell the Insured what additional information is needed to process the claim. The Insured will have 48 hours to provide any additional information requested. We will notify the Insured of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat the Insured's claim as urgent if a delay in processing the claim could seriously jeopardize his or her life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject the Insured to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;

2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support the claim;
4. Information concerning the Insured's right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of the Insured's right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after the Insured receives notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, the Insured may:

1. Send us written comments;
2. Review any non-privileged information relating to the claim; or
3. Provide us with other information or proof in support of the claim.

We will review the claim promptly after receiving the request. We will advise the Insured of the results of our review within 60 days after we receive the request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of the Insured's right to bring a civil action.

If the appeal arises from our denial of an urgent claim, we will consider the appeal and notify the Insured of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the Certificateholder unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Plan. Thank you for your loyal patronage.

Entire Contract, Changes: This Policy together with the application, enrollment forms, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or Application that modifies, limits or excludes coverage under this Plan must be signed by the Certificateholder to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from an Insured's effective date of coverage, no misstatements made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from an Insured's Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Clerical Error: Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Misstatement of Age: If an age has been misstated on the enrollment form, the benefits will be those the premium paid would have purchased at the correct age.

Conformity with State Statutes: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New Employees of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

SECTION VIII POLICY SCHEDULE

MASTER POLICYHOLDER: DOGWOOD STATE BANK

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: UP TO $50,000

PRE-EXISTING CONDITION PERIOD: 0 Days
WAITING PERIOD: 30 Days
IF THIS COVERAGE REPLACES EXISTING SPECIFIED DISEASE WITH CANCER COVERAGE THE CERTIFICATEHOLDER CURRENTLY HAS WITH ANOTHER CARRIER, HE OR SHE WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME THE PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD FOR THE AMOUNT OF COVERAGE THE CERTIFICATEHOLDER PREVIOUSLY HAD IN FORCE.

COVERED SPECIFIED CRITICAL ILLNESSES:
100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

Myocardial Infarction (Heart Attack)	Benign Brain Tumor
Stroke	Major Organ Transplant
Coma	End Stage Renal Disease (Kidney Failure)
Paralysis	Amyotrophic Lateral Sclerosis (ALS)
Severe Burns	Loss of Sight, Speech or Hearing
Alzheimer's Disease	Cancer

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:
Coronary Artery Bypass Surgery
Angioplasty/Stent
Carcinoma in situ (not including Skin Cancer)

Skin Cancer – a $300 one-time (lifetime) benefit is payable for Skin Cancer per Insured Person.

SPOUSE BENEFIT
INSURED SPOUSE Jane Doe
MAXIMUM BENEFIT AMOUNT: UP TO $25,000

DEPENDENT CHILDREN BENEFIT RIDER
MAXIMUM BENEFIT AMOUNT: UP TO $12,500
100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: **Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida**

HEALTH SCREENING BENEFIT RIDER
$50 per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

All Full-Time employees, who are actively at work, and have completed at least 0 months of continuous employment with the Policyholder.

120 ROYALL STREET•CANTON, MASSACHUSETTS 02021•TEL. (800) 669-2668 •FAX (781) 770-0521

DEPENDENT CHILDREN BENEFIT RIDER
TO CERTIFICATE OF INSURANCE FOR SPECIFIED DISEASE AND CANCER

This Rider is a part of the Certificate to which it is attached. We have issued this Rider to you because: (1) you paid the additional premium for this Rider (when applicable); and (2) we relied on the application you made. Unless amended by this Rider, certificate definitions, other provisions and terms apply to this Rider.

Effective Date - If issued at the same time as the certificate, this Rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this Rider will have a later Effective Date, which will be shown in a revised Certificate Schedule Page. Refer to the Effective Date and Termination provision as stated herein.

DEFINITIONS

When the terms below are used in this Rider, the following definitions will apply:

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday but not more frequently than annually thereafter.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

BENEFITS

If a Dependent Child is diagnosed with a Specified Critical Illness, subject to the provisions, limitations and exclusions in the Certificate and this Rider and while this Rider is in force, we will provide the benefits for the Specified Critical Illnesses shown on the Certificate Schedule Page. The appropriate benefit amount we will pay for the Dependent Child is shown on the Certificate Schedule Page. The Pre-Existing Condition limitation does not apply to newborn, adopted or foster Dependent Children.

GENERAL PROVISIONS

If your Dependent Child's coverage is terminated because of attainment of the maximum age, we will still pay benefits for any covered condition that was diagnosed while the Dependent was covered under this Rider.

EFFECTIVE DATE

Coverage for Dependent Children is subject to the following:

1. Newborn children of a Certificateholder and/or his or her Spouse shall automatically be covered from birth. Foster children shall be eligible for coverage on the same basis upon placement in the foster home.
2. Adopted children will be covered the later of the date of birth, the date of placement for purposes of adoption or the date a decree of adoption is entered by the Certificateholder and/or his or her Spouse. A decree of adoption must be entered within one year from the date proceedings were instituted, unless extended by order of the court, and the Certificateholder and/or his or her Spouse must continue to have custody pursuant to the decree of the court.

Any enrollment period restrictions are waived when You are required to provide coverage for a Dependent Child pursuant to an administrative or court order.

TERMINATION – Coverage for the Dependent Children or Dependent Child will end on the earliest of the following:

1. When the Certificate terminates;
2. The date We receive Your written request to cancel the Rider (in which case the grace period will not apply);
3. When the Dependent Children or Dependent Child does not qualify as a dependent of You or Your Spouse as defined in this Rider.

CONTRACT -This Rider is part of the Certificate, and will terminate when the certificate terminates, or when premiums are no longer paid for this Rider. This Rider is subject to all of the terms of the certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office

Paul A. Quaranto Jr.
President

Grant David Ward
Secretary

120 ROYALL STREET•CANTON, MASSACHUSETTS 02021•TEL. (800) 669-2668 •FAX (781) 770-0521

BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

HEALTH SCREENING BENEFIT RIDER
TO CERTIFICATE OF INSURANCE FOR SPECIFIED DISEASE AND CANCER

This rider is a part of the certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, certificate definitions and other provisions and terms apply to this rider.

Effective Date – If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown on a revised Certificate Schedule Page.

Health Screening Benefit (Calendar Year Limit)

We will pay this benefit for the following Health Screening Tests performed after the Waiting Period and while this Rider is in force. We will pay the Health Screening Benefit amount shown on the Certificate Schedule Page for any one of the following Health Screening Tests. This benefit is payable once per Calendar Year. Payment of this benefit will not reduce the Maximum Benefit Amount of the Certificate. This benefit is not paid for Dependent Children. There is no limit to the number of years you can receive benefits for Health Screening Tests, as long as this Rider is in force. We will pay this benefit regardless of the results of the test.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides
4. Lipid Panel (total cholesterol count)
5. Bone marrow testing,
6. CA 15-3 (blood test for breast cancer),
7. CA 125 (blood test for ovarian cancer),
8. CEA (blood test for colon cancer),
9. Chest X-ray
10. Electrocardiogram (EKG)
11. Colonoscopy
12. Flexible sigmoidoscopy
13. Hemocult stool analysis
14. Mammography/Breast Ultrasound
15. Pap smear (including ThinPrep Pap Test)
16. PSA (.blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma)
18. Thermography
19. Oral Cancer screening using ViziLite OraTest or other similar test
20. Biopsy for Skin Cancer

LIMITATIONS AND EXCLUSIONS

WAITING PERIOD
This Rider contains a Waiting Period. This means no benefits are payable for any insured person who has a Health Screening Test during the Waiting Period. If coverage is approved and premiums are paid, the Waiting Period begins from the Rider Application Date. The Waiting Period is shown on the Certificate Schedule Page.

GENERAL PROVISIONS

This Rider is part of the certificate and will terminate when that certificate terminates, or when premiums are no longer paid for this Rider. The premium for this Rider is shown on the Certificate Schedule Page.

This Rider is subject to all the terms of the certificate to which it is attached unless any such items are inconsistent with terms of this Rider.

Signed for the Company at its Home Office

Paul A. Quaranto Jr.
President

Grant David Ward
Secretary

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

IMPORTANT NOTICE

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS.

THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company

(Herein referred to as "we", "us", "our")

FAMILY MATTERS NO MATTER WHAT

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf
- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

BOSTON MUTUAL LIFE INSURANCE COMPANY
- 1891 -

120 Royall Street
Canton, MA 02021
800-669-2668

APPLICATION FOR GROUP SPECIFIED DISEASE [WITH CANCER] INSURANCE

by : Dogwood State Bank
Employer/Union Name

of : 5401 Six Forks Rd. Raleigh, NC 27609
Home Office Location (City & State)

for a Plan of Specified Disease Insurance, and representations are made as follows:

1. Class of Employees/Members eligible for coverage:

- o Number of regular full-time employees/members: 150
- o Other: _____

A full-time employee/member is defined as one who works 30 *hours or more per week. An employee must be Actively at Work on the date he/she applies for insurance, and on the date his/her Insurance is to become effective. An employee must have completed* 0 *months of continuous service before being eligible.*

2. The minimum number of enrolled employees/members necessary to keep the Group Policy in force is: 5

3. Effective Date – The requested effective date of the Group Master Policy is: 3/1/2023

4. Optional Features: T/NT rates, with Cancer, No A70, No PE, $50 HSB

5. Will this Specified Disease [with Cancer] Policy replace any existing group critical illness policy?

☐ Yes ☑ No

6. General Agreement:

The applicant agrees to transmit the total premiums under the group policy to the Insurer named below at its home office when due. No agent or other person except an officer can make or change any contract or agreement on behalf of the Insurer named below.

Caution: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I certify that I have truly and accurate recorded the information supplied by the applicant.

Signature of Employer/Union Representative	Date 10/19/2022
Signature of Agent	Date 10/19/2022

Director of Human Resources
Title

Underwritten by:

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -