dun & bradstreet

The Dun & Bradstreet Life Insurance Plan Summary Plan Description for Active Employees

Table of Contents

HOW TO REACH YOUR LIFE INSURANCE PLAN SERVICE PROVIDER......... 5

ABOUT YOUR PARTICIPATION 6

Who Is Eligible.. 6

When Coverage Begins 8

Naming a Beneficiary.. 9

Paying for Coverage... 10

When Coverage Ends 11

Making Changes During the Year... 13

If Your Employment Situation Changes 14

YOUR LIFE INSURANCE BENEFITS 15

Life Insurance Coverage Options.. 15

Evidence of Insurability 16

Accelerated Payments 17

Reduction of Coverage... 17

What's Not Covered.. 18

Conversion or Continuation of Your Life Insurance Coverage 19

Filing a Claim.. 19

PLAN ADMINISTRATION... 20

CONTINUATION OF COVERAGE 24

Continuation of Coverage for Employees in the Uniformed Services 24

Continuation of Coverage While on a Family and Medical Leave 25

Internal Use Only

Continuation of Coverage While on an Employer-Approved Leave of Absence 26

CLAIMS AND APPEALS PROCESS 27

Authorized Representative 27

Time Frame for Claim Determinations 28

If You Receive an Adverse Benefit Determination 28

Procedures for Appealing an Adverse Benefit Determination 29

Special Rules for Disability Claim Determinations 30

Discretionary Authority 36

YOUR RIGHTS UNDER ERISA 38

NO GUARANTEE OF EMPLOYMENT 40

The Dun & Bradstreet Corporation Welfare Benefit Plan provides health care, life, accident, disability, employee assistance, flexible spending account and legal insurance benefits to eligible active employees of Dun & Bradstreet and its related companies who participate in the plan, and their dependents. The Dun & Bradstreet Life Insurance Plan for active employees (the "Life Insurance Plan" or "Plan") is part of The Dun & Bradstreet Corporation Welfare Benefit Plan and provides life insurance benefits to active employees. This document summarizes the Dun & Bradstreet Life Insurance Plan, as in effect on January 1, 2025, unless otherwise noted, for eligible active employees and their eligible dependents. It describes the benefits as they apply to eligible participants and serves as the summary plan description (SPD) for these benefits. Life insurance plan benefits for retirees are part of a different plan and are described in a separate SPD.

Dun & Bradstreet encourages you to read this SPD carefully and share it with your eligible dependents covered under the Life Insurance Plan. If you have any questions about your benefits, please contact the Dun & Bradstreet Benefits Center. See the section "How to Reach Your Life Insurance Plan Service Provider" at the beginning of this SPD for contact information.

The insurance policy and the Dun & Bradstreet legal plan document provide additional information about the administration of the Life Insurance Plan. If there is any difference between the information in this SPD and information in the insurance policy and Dun & Bradstreet legal plan document, or if there are details not covered in this SPD, the insurance policy and Dun & Bradstreet legal plan document will determine how to resolve these issues.

Important Information

The Dun & Bradstreet Corporation (Dun & Bradstreet or the "Company") is the Plan Sponsor of the Life Insurance Plan.

The Life Insurance Plan is fully insured through an outside insurance company (the "Insurance Provider"), which means the Insurance Provider assumes full responsibility for claims adjudication and payment. Day-to-day operations of the Life Insurance Plan have been delegated to the Benefits Center for The Dun & Bradstreet Corporation (the "Dun & Bradstreet Benefits Center").

You can contact the Insurance Provider or the Dun & Bradstreet Benefits Center if you have questions or need more information. See the section "How to Reach Your Life Insurance Provider" at the beginning of this SPD for contact information.

HOW TO REACH YOUR LIFE INSURANCE PLAN SERVICE PROVIDER

Here is how you can reach your Dun & Bradstreet Life Insurance Plan service providers:

Provider	Contact Information
Dun & Bradstreet's Benefits Center at Fidelity*	P.O. Box 770003 Cincinnati, OH 45277 1-877-362-8953 (or 1-888-343-0860 for the hearing impaired) http://netbenefits.fidelity.com

*For assistance before you have terminated employment or before you have submitted a claim for benefits. The Insurance Provider can provide assistance after you have terminated employment or after you have submitted a claim for benefits. Contact information for the Insurance Provider is located in the "Plan Administration" section.

Internal Use Only

ABOUT YOUR PARTICIPATION

This section contains important information about your participation in the Life Insurance Plan including eligibility information, when coverage begins, naming beneficiaries, paying for coverage, making changes during the year and when coverage ends.

Who Is Eligible

You are eligible for coverage under the Life Insurance Plan if you meet all of the following conditions:

- You are an active full-time or part-time employee employed by Dun & Bradstreet or a related company that participates in the Life Insurance Plan with Dun & Bradstreet's approval, and
- You are regularly scheduled to work 20 or more hours per week.

If you are classified by a Dun & Bradstreet company as a temporary employee, leased employee, intern, or an independent contractor, you are not eligible to participate in the Life Insurance Plan.

In addition, if you are not classified as an eligible employee by a Dun & Bradstreet company, but are later reclassified as such either by action of the Plan Administrator or by a governmental or judicial authority, you will be deemed to have become an employee eligible to participate in the Life Insurance Plan only prospectively and not retroactively to the date on which you are found to have first become an employee, assuming all other eligibility requirements are met.

Eligibility of Rehired Retirees

If you are participating in the Retiree Life Insurance Plan and you are hired or rehired by Dun & Bradstreet or a related employer, your coverage under the Retiree Life Insurance Plan will terminate, and you will be eligible to participate in the Life Insurance Plan for active employees only if you satisfy the applicable eligibility requirements. When you later terminate employment, you will not be allowed to re-enroll in the Retiree Life Insurance Plan.

Dependent Eligibility

Your eligible dependents are also eligible for coverage under the Life Insurance Plan.

Eligible dependents include:

- Your legal spouse (not including your legally separated or divorced spouse) or your same-sex or opposite-sex domestic partner provided he or she is under 70 years of age,
- Your or your spouse's/domestic partner's dependent child(ren) who are under age 26 as of the last day of the calendar year.
- Your or your spouse's/domestic partner's eligible dependent child who is physically or mentally incapable of self-support will continue to be eligible after age 26 for coverage as long he or she is financially dependent on you for more than one-half of his or her maintenance and support as long as the disability continues. Certification of disability must be approved by the Plan Administrator. The Plan Administrator will review and re-certify eligibility for continued coverage at its discretion from time to time.

Eligible children may include:

- Biological children,
- Adopted children (eligible as of the date of birth if legally adopted before birth; otherwise, eligible as of the date they are placed in your home),
- Stepchildren,
- Foster children, and
- Children placed in your care by court order.

The following dependents will not be eligible for Life Insurance Plan coverage:

- Dependents who live outside the U.S. or Canada,
- Dependents in the military of any country or subdivision of any country,
- Dependents who are covered under the Life Insurance Plan as a Dun & Bradstreet employee, or
- Dependents who are no longer eligible dependents under the terms of the Life Insurance Plan.

Domestic Partner Eligibility

Your domestic partner may be eligible for coverage under the Life Insurance Plan. In order for you to cover your domestic partner, you and your partner must either:

Internal Use Only

- Have registered properly your domestic partnership with an approved governmental domestic partnership registry,

OR

- Be at least 18 years old;
- Share a committed and exclusive relationship for at least six months;
- Not be married to another person;
- Not be related by marriage or blood, which would otherwise prohibit legal marriage in the state of residence, and
- Live together in the same household.

OR

- Enter into a civil union in accordance with the laws of a state which permits couples to enter into civil unions.

If any of the above eligibility requirements are no longer being met, domestic partner coverage ends. You must notify the Dun & Bradstreet Benefits Center immediately. See the section "How to Reach Your Life Insurance Plan Service Provider" at the beginning of this SPD for contact information.

When Coverage Begins

Company-Paid Life Insurance

You are automatically enrolled in Company-paid life insurance on your first date of employment or the date you first become eligible provided you are actively at work on that date.

Supplemental Life Insurance

If you enroll for Supplemental Life Insurance coverage that does not require evidence of insurability, coverage will be effective the day you began employment with a Dun & Bradstreet company or first became eligible, *provided* you are actively at work on that date and enroll within the required time period. Coverage that requires evidence of insurability will be effective on the

date it is approved, provided you are active at work on that date. If you are absent from work on the day your coverage is scheduled to begin, you will not be eligible for the coverage until you return to active work.

If you enroll at any other time during the year, your coverage will be effective once your enrollment is processed by the Plan Administrator and evidence of insurability (if required) is approved provided you are actively at work on that date. If you enroll during annual enrollment, your coverage will be effective on the following January 1 or the date you are actively at work, if later, provided evidence of insurability (if required) is approved. Coverage that requires evidence of insurability will be effective on the date it is approved (but not before January 1 if you enroll during open enrollment), provided you are actively at work on that date. If you are absent from work on the day your coverage is scheduled to begin, you will not be eligible for the coverage until you return to active work.

Spouse Life Insurance

Coverage for your dependent(s) that does not require evidence of insurability starts the date your dependent is first eligible (or January 1 if you enroll during open enrollment), if you have enrolled for coverage within the required time period, *unless* your dependent is hospitalized or confined because of illness or disease. Coverage that requires evidence of insurability will be effective on the date it is approved (but not before January 1 if you enroll during open enrollment), provided your dependent is not hospitalized or confined because of illness or disease in which case coverage will begin when he or she is released.

Child Life Insurance

Coverage for your eligible dependent child(ren) starts the date your dependent is first eligible (or January 1 if you enroll during open enrollment), if you have enrolled for coverage within the required time period, *unless* your dependent is hospitalized or confined because of illness or disease (except in the case of a newborn) in which case coverage will begin when he or she is released.

Naming a Beneficiary

You have the right to choose a beneficiary under the Life Insurance Plan. A beneficiary is the person you choose to receive the insurance benefits when you die. You can name one or more

Internal Use Only

beneficiaries to receive insurance payments in the event of your death. You may want to review your beneficiary designation periodically. For example, if you get married or divorced, you may want to name a new beneficiary.

To designate your beneficiaries, visit Fidelity NetBenefits online at http://netbenefits.fidelity.com Click on the Your Profile tab, then Beneficiaries to designate your beneficiaries.

If you fail to name a beneficiary or your beneficiary predeceases you, your life insurance benefits will be paid in accordance with the insurance policy, which provides for payment to the first of the following:

- Your surviving spouse/domestic partner,
- Any surviving biological or legally adopted child(ren) in equal shares,
- Any surviving parents in equal shares,
- Any surviving biological or legally adopted siblings in equal shares,
- Your estate.

If you name more than one beneficiary without specifying their shares, they will receive equal shares. If your beneficiary(ies) dies before you, their interest will end. Your benefit will be shared equally by any remaining beneficiaries. If you and your beneficiary die at the same time, your benefit will be paid as if you survived your beneficiary.

Paying for Coverage

Dun & Bradstreet pays the full cost of the Company-Paid Life Insurance coverage provided to you under the Life Insurance Plan.

You pay the full cost of coverage for Supplemental and Dependent Life Insurance. Your cost of coverage will depend on how much coverage you elect to purchase and your and your dependent's age. Contributions are deducted from your paycheck on an after-tax basis; that is, after federal and state income taxes and FICA taxes are withheld from your paycheck.

Imputed Income

Under federal tax law, a portion of the value of the premiums you pay for life insurance in excess of $50,000 may be considered “imputed income”. The amount of imputed income is determined by comparing the premiums you pay for coverage to premiums established by the Internal Revenue Code (IRC) for employer provided life insurance. If the premiums you pay are lower than the IRC premiums, you will have imputed income on the difference between the premiums you pay and the IRC premiums. This imputed income will be added to your annual compensation for federal income tax and FICA tax purposes. Your imputed income for life insurance will be included on your pay stub and reported to you and the IRS on your W-2 form.

When Coverage Ends

Coverage under the Life Insurance Plan will end *for you* on the earliest of the following events:

- Date you die,
- End of the period for which premiums are paid on a timely basis,
- Date Dun & Bradstreet terminates this Life Insurance Plan,
- Date you cancel coverage, or
- End of the month in which your employment ends, including on account of retirement, or you otherwise fail to satisfy the eligibility requirements.

Your *dependent's* coverage will end on the earliest of the following events:

- Date you die,
- Date Dun & Bradstreet terminates all dependent coverage under this Life Insurance Plan,
- Date Dun & Bradstreet terminates this Life Insurance Plan,
- Date your dependent becomes covered as a Dun & Bradstreet employee,
- Date your dependent no longer meets the definition of an eligible dependent,
- Date your coverage terminates, or you are no longer eligible for coverage, or

- End of the period for which premiums are paid on a timely basis.

You may be eligible to continue your life insurance coverage or convert your coverage to an individual life insurance policy offered by the Insurance Provider when coverage ends. See the section “Conversion or Continuation of Your Life Insurance Coverage” in this SPD for more information.

Your coverage (or your dependent’s coverage) will also terminate on the date you revoke your election for such coverage (which generally must be prospectively) provided the revocation is otherwise permitted under the terms of the Life Insurance Plan.

If the Plan Administrator determines that you or your dependent have engaged in fraud or intentionally misrepresented a material fact in connection with the Life Insurance Plan, including enrollment and participation, your coverage and/or your dependent’s coverage will be terminated on the date specified by the Plan Administrator.

Internal Use Only

Making Changes During the Year

You can reduce or cancel coverage at any time by contacting Dun & Bradstreet's Benefits Center.

Qualified Changes in Family Status

Qualified family status changes under the Life Insurance Plan include:

- A change in your legal marital status (such as marriage, divorce, death of spouse) or domestic partner status (i.e. your domestic partner meets or fails to meet the domestic partner criteria),
- Your spouse loses their employer coverage, and
- A change in the number of your dependents (such as through birth, adoption or placement for adoption of a dependent child, child is no longer eligible, or death).

If you experience one of these qualifying events, you must notify Dun & Bradstreet's Benefits Center within 31 days from the date of the event to make changes.

Internal Use Only

If Your Employment Situation Changes

The following chart summarizes how your Life Insurance coverage may be affected if your employment situation changes.

If You……	How Your Life Insurance Coverage May Change…
Terminate employment and you are totally disabled[1]:	■ Coverage will continue for you for 6 months provided you pay the required contributions for coverage on a timely basis. Spouse Life and Child life will be terminated. See the section "Conversion or Continuation of Your Life Insurance Coverage" of this SPD for information about conversion or continuation privileges after coverage terminates.
Take an approved leave of absence, including: ■ An approved unpaid personal leave. ■ A family leave of absence under the Family and Medical Leave Act (FMLA); or ■ A short-term disability leave	■ Coverage will continue for you and your eligible covered dependents as long as you are on an approved leave, and you pay the required contributions for coverage on a timely basis. ■ If your leave is paid, the cost of coverage will be deducted from your pay. If you are on an unpaid leave, you will be billed monthly for the cost of your life insurance coverage by the Dun & Bradstreet Benefits Center.
Leave the Company for any reason	■ Your coverage stops the day your employment ends. ■ You may be eligible to continue your coverage or convert your life insurance coverage to an individual policy. ■ See the section "Conversion or Continuation of Your Life Insurance Coverage" in this SPD for more information about conversion and continuation privileges.
Die	■ Your designated beneficiary(ies) should notify the Dun & Bradstreet Benefits Center of your death and request the appropriate claim form. ■ See the section "How to Reach Your Life Insurance Plan Service Provider" at the beginning of this SPD for contact information.
Are on military leave	■ Coverage will continue for you and your eligible covered dependents as long as you are on an approved military leave, and you pay the required contributions for coverage on a timely basis.

[1] Totally disabled is a disability which occurs while you are covered and results from an accidental injury or an illness that continuously prevents you from engaging in any occupation for which you are reasonably suited by education, training or experience on a full-time or part-time basis, as determined by the Insurance Provider.

Internal Use Only

YOUR LIFE INSURANCE BENEFITS

The Life Insurance Plan is designed to help provide protection for your family's financial well-being. The following summarizes the life insurance coverage options that Dun & Bradstreet offers you, your spouse/domestic partner and your dependent children and the EOI requirements for each coverage option. For additional detail, you should review the Certificate of Insurance for the Life Insurance Plan which was prepared by the Insurance Provider.

CERTIFICATE

OF

COVERAGE

In the event of a conflict between this summary and the Certificate of Insurance, the Certificate of Insurance will control.

Annual Earnings

Your annual earnings include your gross annual base salary (including lump sum salary or wage increases) and your prior year's cash bonus and commissions (including one-time payments due to a reduction in regular bonus or commission opportunity as a result of a job change). For example, base salary as of September 2024 and bonus and commission for 2023 are combined for annual earnings for 2025 Annual enrollment.

If you are newly hired, your annual earnings equal your gross annual salary or draw, if you earn sales commissions.

Your annual earnings *do not include* overtime pay, pension payments, retainers, prizes and awards and other special remuneration.

Annual earnings are recalculated once a year in September and effective the following January 1 as part of your Annual Enrollment.

Life Insurance Coverage Options

Company-Paid Life Insurance

Dun & Bradstreet automatically provides eligible employees with Company-paid life insurance coverage equal to 100% of your annual earnings (rounded up to the next $1,000), to a maximum of $100,000. No EOI is required for this coverage and the benefit is paid to your beneficiary(ies) in the event of your death.

Internal Use Only

Supplemental Life Insurance

You have the option to buy Supplemental Life Insurance coverage for yourself. This benefit is paid to your beneficiary(ies) in the event of your death.

You can choose any from the following options - 1x, 2x, 3x, 4x, 5x, 6x or 7x your annual earnings (rounded up to the next higher $1,000 if not already a multiple thereof), subject to a maximum of $4,000,000.

Spouse/Domestic Partner Life Insurance

You have the option to buy coverage for your spouse/domestic partner. You can choose coverage from $10,000 to $50,000 (in $10,000 increments) and $75,000 to $150,000 (in $25,000 increments). Spouse Life coverage cannot exceed the combined amounts of your Company-paid Life and Supplemental Life election.

Child Life Insurance

You have the option to buy $10,000 of life insurance coverage for your and your spouse's/domestic partner's dependent children. If both you and your spouse/domestic partner work for Dun & Bradstreet, only one of you can purchase life insurance coverage for your dependent children.

Evidence of Insurability

You will be required to provide Evidence of Insurability (EOI) to the Insurance Provider if you delay enrollment beyond 31 days from the date you are first eligible for coverage or if you elect or increase your life insurance coverage in excess of certain limits. EOI may include undergoing a physical examination Your additional or increased coverage will not go into effect unless the Insurance Provider approves your application.

EOI is never required if you want to purchase Child Life for your or your spouse/domestic partner's eligible dependent children.

Following are the rules for providing EOI under the Life Insurance Plan:

Internal Use Only

Supplemental Life Insurance Coverage

- If you enroll for Supplemental Life Insurance within 31 days of the date you are first eligible, you will *not* need to provide EOI for coverage up to $1,500,000 or 4x your annual earnings, if less.

- If you delay enrollment for Supplemental Life Insurance coverage, you *will* need to provide EOI if you later enroll.

- If you experience a qualified change in family status, and you are enrolled in coverage, you may be able to elect to increase your Supplemental Life Insurance coverage by 1x your annual earnings (not to exceed to $1,500,000 or 4x your annual earnings) *without* providing EOI provided that you enroll within 31 days of the event. All other increases will require EOI.

Spouse/Domestic Partner Life Insurance Coverage

- If you enroll for Spouse/Domestic Partner coverage within 31 days of the date you are first eligible, your spouse/domestic partner will *not* be required to provide EOI for the first $30,000 coverage. For Spouse/Domestic Partner coverage in excess of $30,000 your spouse/domestic partner will be required to provide EOI.

- If you delay enrollment for coverage for your spouse/domestic partner, you *will* need to provide EOI

- If you experience a qualified change in family status that is marriage or acquisition of a new domestic partner, you may enroll for coverage up to $30,000 without providing EOI if you enroll within 31 days of the event.

Accelerated Payments

Under the Life Insurance Plan, you can choose to receive accelerated life insurance benefits if you or your spouse/domestic partner becomes terminally ill, as determined by the Insurance Provider. Generally, a terminally ill person is someone whose life expectancy is six months or less due to an illness or accident.

If you wish to receive an accelerated benefit payment, you must submit written proof to the Insurance Provider from your doctor that you, your spouse/domestic partner or dependent child are terminally ill. The accelerated payment will be made in a single sum unless you elect another form of payment. If you elect the accelerated benefit option, any payment made under this option may be taxable to you. You are advised to seek the help of a professional tax advisor for assistance with questions you may have about accelerated life insurance payments.

For more information about accelerated life insurance payments, you should review the Certificate of Insurance for the plan (link provided above). See the section "How to Reach Your Life Insurance Provider" for contact information.

Reduction of Coverage

If you are under age 65 when your Company-paid Life Insurance coverage begins, at age 65 your coverage is reduced to 65% of the amount in effect on the day before your 65th birthday. If you are age 65 or older when your coverage begins, the amount will be reduced to 65% of the total benefit amount.

When your coverage is reduced if you are age 65 or older, your spouse's/domestic partner's life insurance coverage may be reduced to ensure that your spouse's/domestic partner's coverage amount does not exceed 100% of your coverage amount.

What's Not Covered

If you have Supplemental Life Insurance and you commit suicide within 2 years of the date your Supplemental Life Insurance began, benefits payable to your beneficiary will be limited to a return of any premiums paid by you. Any premiums paid by the Company for Company-paid Life Insurance will be returned to the Company. No additional benefits will be payable to your beneficiary.

If you increased your Supplemental Life Insurance and commit suicide within 2 years of the increase, benefits payable to your beneficiary will be limited to the Company-paid and Supplemental Life Insurance coverage in effect for more than 2 years and a return of any premiums paid by you for the increased Supplemental Life Insurance coverage.

If your dependent has Dependent Life Insurance and they commit suicide within 2 years of the date their Dependent Life Insurance began, benefits payable to you will be limited to a return of any premiums paid by you. No additional benefits will be payable to your beneficiary.

If you increased your Dependent Life Insurance and your Dependent commits suicide within 2 years of the increase, benefits payable to you will be limited to the Dependent Life Insurance coverage in effect for more than 2 years and a return of any premiums paid by you for the increased Dependent Life Insurance coverage.

Conversion or Continuation of Your Life Insurance Coverage

If your or your spouse's/domestic partner's life insurance coverage is reduced or ends, you or your spouse/domestic partner may have the option to continue your group coverage or convert coverage to an individual policy offered by the Insurance Provider. You must exercise this right within a certain period time after coverage ends.

For more information about conversion or continuation privileges, including how to determine if you are eligible, you should review the Certificate of Insurance for the plan (link provided above)

Filing a Claim

In the event of your death (or your spouse's/domestic partner's or your child(ren)'s death), the beneficiary(ies) should file a claim and provide valid proof of death to the Insurance Provider as soon as possible. The beneficiary(ies) should contact the Dun & Bradstreet Benefits Center to receive a claim form. See the section "How to Reach Your Life Insurance Plan Service Provider" at the beginning of this SPD for contact information.

Internal Use Only

PLAN ADMINISTRATION

This information about the administration of the Life Insurance Plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Life Insurance Plan.

Plan Name

The name of the plan is The Dun & Bradstreet Corporation Welfare Benefit Plan. The Life Insurance Plan for active employees is one part of this plan.

Plan Sponsor

The Dun & Bradstreet Corporation is the Plan Sponsor of The Dun & Bradstreet Corporation Welfare Benefit Plan, of which the Life Insurance Plan is a part. The name, address and telephone number of the Plan Sponsor are:

The Dun & Bradstreet Corporation
5335 Gate Parkway
Jacksonville, FL 32256
1-800-234-3867

This plan is a welfare benefit plan providing life insurance benefit.

Participating Employers

As of January 1, 2025, the participating employers are:

The Dun & Bradstreet Corporation
Dun & Bradstreet Credibility Corporation
Dun & Bradstreet, Inc.

For a complete list, please contact the Plan Administrator.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

The Plan Administration Committee
The Dun & Bradstreet Corporation
100 Campus Drive, 3rd Floor West
Florham Park, NJ 07932
1-973-921-5500

The administration of the Life Insurance Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive right to determine all matters relating to eligibility, coverage determination, interpretation, and operation of the Life Insurance Plan.

Insurance Provider

Listed below are the name and address of the organization that insures the life insurance benefit and provides related insurance services. The Insurance Provider can provide assistance after you have terminated employment or after you have submitted a claim for benefits. These services include providing plan benefits, administering claims, and providing customer assistance. If you need assistance before you have terminated employment or before you have submitted a claim for benefits, you should contact the Dun & Bradstreet Benefits Center.

Securian Financial Group, Inc.
400 Robert Street North
St Paul, MN 55101

The Plan Administrator has delegated to the Insurance Provider full discretion to determine all matters relating to claims, up to and including final appeals. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

The Plan Administrator is the designated agent for service of legal process. See the section “Plan Administrator” for more information.

Internal Use Only

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Dun & Bradstreet is 22-3725387. The plan number for The Dun & Bradstreet Corporation Welfare Benefit Plan is 501.

Plan Year

The plan year for the Life Insurance Plan is January 1 through December 31.

Plan Funding

The Life Insurance Plan is fully insured, which means the Insurance Provider assumes full responsibility for claims adjudication and payment of benefits. Dun & Bradstreet pays the cost of the Company paid life insurance and participants pay the cost of supplemental life insurance, Spouse/Domestic Partner life insurance and Child life insurance.

Plan Document

This SPD is intended to help you understand the main features of the Life Insurance Plan. The insurance policy and Dun & Bradstreet legal plan document provide additional information about the administration of the Life Insurance Plan. If there is any difference between the information in this SPD and in the insurance policy and Dun & Bradstreet legal plan document, or if there are details not covered in this SPD, the insurance policy and Dun & Bradstreet legal plan document will determine how to resolve these issues.

Future of the Plan

Dun & Bradstreet reserves the right to amend, modify, suspend, or terminate the plan, in whole or in part, by action of the Compensation Committee of the Company's Board of Directors (or any delegate from time to time). Plan amendment, modification, suspension, or termination may be made for any reason, and at any time.

Limitation on Assignment

You may assign your rights and ownership under the Life Insurance Plan. You must make the assignment in writing, and it must be signed by you. You must file the original assignment (or a

Internal Use Only

certified copy) with the Insurance Provider. Both Dun & Bradstreet and the Insurance Provider must give written consent to such an assignment. If you have made an irrevocable assignment under a group life insurance policy that is replaced by the Dun & Bradstreet Life Insurance Plan, the Insurance Provider may recognize the irrevocable assignment if it is in writing, signed by you and both Dun & Bradstreet and the Insurance Provider approved the assignment. You should contact the Insurance Provider for additional information. See the section "How to Reach Your Life Insurance Plan Service Provider" for contact information.

Neither Dun & Bradstreet nor the Insurance Provider is responsible for the legality of the assignment. Therefore, you should consult with your attorney before taking this action.

Internal Use Only

CONTINUATION OF COVERAGE

You may be able to continue coverage under the Life Insurance Plan under certain conditions.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees with regards to military service. If you go on a qualifying military leave of absence, you are generally entitled to participate in any rights under benefits not based on seniority that are available to employees on comparable non-military leaves. Upon reinstatement to active employment with your employer, you are generally entitled to the seniority, and all seniority-based rights and benefits associated with the position that you held at the time your employment was interrupted, plus the additional seniority; and seniority-based rights and benefits that you would have attained with reasonable certainty if your employment had not been interrupted.

You may continue your life insurance coverage while on military leave pursuant to USERRA subject to any Insurance Provider limit by paying the same amount charged to active employees for the same coverage.

If you chose not to continue your life insurance coverage while on military leave, you are generally entitled to reinstate your coverage with no waiting periods or exclusions (however, an exception applies to service-related injuries or illnesses) when you return to active employment with your employer.

To be eligible for the reemployment rights guaranteed by USERRA, you must meet certain requirements. One of these requirements is that you generally must return to active employment with your employer (or reapply for employment with your employer, as applicable) within the following time frames:

- Return to work no later than the beginning of the first full, regularly scheduled workday following military service, including an 8-hour rest period after you return home from your military service, if you are on a military leave of less than 31 days,

- Return to or reapply for employment within 14 days of completion of such period of duty, if your period of military service is more than 30 days and less than 180 days, or

- Return to or reapply for employment within 90 days of completion of your period of duty if your military service lasts more than 180 days.

See your Human Resources representative for more information on applicable military leaves of absence.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) for certain family and medical situations.

If you are eligible, you can take up to 12 weeks of unpaid leave (26 weeks in the case of a military caregiver leave) in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care,
- For the care of a spouse, child, or parent who has a serious health condition,
- For your own serious health condition,
- For a qualifying exigency relating to the active duty, or call to active duty, of a family member who is a member of the US Armed Forces or of the reserves and who is deployed to a foreign country, or
- To care for a family member who is a member of the US Armed Forces or a veteran and who is being treated for or recovering from a serious injury or illness incurred or aggravated by service in the course of active duty (known as a “military caregiver leave”).

Depending on the state you live in, the number of weeks of leave available to you for family and medical reasons may vary based on state law requirements.

Your participation in the Life Insurance Plan will continue while you are on an approved FMLA Leave (paid or unpaid) as long as you pay the required premium for coverage in a timely manner. If your leave is unpaid, you will be billed for the cost of coverage under the Life Insurance Plan. If you do not pay the required premium in a timely manner your coverage will terminate. If you do not

return to work at the end of the FMLA leave and your leave of absence is not extended, your coverage under the Life Insurance Plan will terminate.

Continuation of Coverage While on an Employer-Approved Leave of Absence

If you take an approved leave of absence (whether paid or unpaid), your coverage under the Life Insurance Plan will continue at active rates during your approved leave of absence subject to timely payment of the required premium and any Insurance Provider limit, with the exception of an FMLA or USERRA leave where you may choose to decline your benefit continuation. If you take a non-medical leave of absence, your coverage cannot continue for longer than 12 months from the last day you were actively at work. If you take a medical leave of absence, your coverage cannot continue for longer than 12 months from the last day you were actively at work or you turned age 65, whichever is earlier.

If your leave of absence is paid, the cost of your coverage will be deducted from your pay. If your leave of absence is unpaid, you will be responsible for submitting payments for the required premium on a timely basis to continue coverage, otherwise your coverage will be terminated. The Dun & Bradstreet Benefits Center will bill you on a monthly basis for the cost of coverage starting the first of the month following the start of your approved unpaid leave. Payroll deductions will resume the first of the month following your return from the approved unpaid leave.

Your coverage may terminate before the end of your approved leave of absence if any of the other termination events described in the section "When Coverage Ends" occur, including your failure to pay the required contributions for coverage on a timely basis.

Internal Use Only

CLAIMS AND APPEALS PROCESS

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations either yourself or through an authorized representative. All claims must be submitted in writing. Any reference to "you" in this Claims and Appeals Process section includes you and your Authorized Representative. Additional information regarding appointment of an Authorized Representative is provided below.

If your claim is denied (in whole or in part), you will receive a written notice of the denial which will explain the reasons for the denial and the appeal procedures available under the Plan. Additional information is provided below.

The Insurance Provider is responsible for determining all claims for benefits under the Life Insurance Plan. The Plan Administrator will determine all eligibility claims and other similar non-benefit claims. The Plan Administrator will respond to all such claims within the time frames and in the manner that claims for benefits are decided, but you must submit the claim to the Plan Administrator, not to the Insurance Provider. All appeals of such claims must also be filed with the Plan Administrator within 60 days of the denial. The Plan Administrator will respond to all such appeals within the time frames and in the same manner as claims for life insurance benefits.

Authorized Representative

You may appoint an authorized representative to act on your behalf for purposes of the Life Insurance Plan.

If you need to appoint an authorized representative for purposes of a claim or appeal relating to benefits, you must follow the rules and procedures of the Insurance Provider for such claim or appeal. To the extent the Insurance Provider has no rules or procedures, your appointment of an authorized representative must:

- Be in writing and dated;
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative;
- Be signed by you and notarized by a notary public;

- Satisfy any other legal requirement applicable to appointments under state or federal law; and
- Be approved by the Plan Administrator (or its delegate) in writing.

The Life Insurance Plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of an Insurance Provider or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

Time Frame for Claim Determinations

The Insurance Provider will notify you of any adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be extended for up to an additional 90 days, if the Insurance Provider both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 90-day period expires, of the special circumstances requiring the extension of time and the date by which the Life Insurance Plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the Life Insurance Plan's time frame for making a benefit determination on review is stopped from the date the Insurance Provider sends you the extension notification until the date you respond to the request for additional information. If the Insurance Provider does not receive the requested information from you within 60 days of the date the Insurance Provider sends you the request, your claim will be considered without such additional information and the resulting claim determination by the Insurance Provider will be final. No additional appeals with respect to such claim will be available to you under the terms of the Life Insurance Plan.

If You Receive an Adverse Benefit Determination

The Insurance Provider will provide you with a notification of any adverse benefit determination (such as any denial, reduction or termination of a benefit, or a failure to provide or make a payment), which will set forth:

Internal Use Only

- The specific reason(s) for the adverse benefit determination.
- References to the specific Life Insurance Plan provisions on which the benefit determination is based.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the Life Insurance Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse determination.

Procedures for Appealing an Adverse Benefit Determination

You or your authorized representative has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. In connection with an appeal, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
- Request a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

The Insurance Provider will notify you of the Life Insurance Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of your request for review by the Life Insurance Plan. This 60-day period may be extended for up to an additional 60 days, if the Insurance Provider both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Life Insurance Plan expects to render a determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the Life Insurance Plan's time frame for making a benefit determination on review is stopped from the date the Insurance Provider sends you the extension notification until the date you respond to the request for additional information. If the Insurance Provider does not receive the requested information from you within 60 days of the date the Insurance Provider sends you the request, your claim will be considered without such additional information and the resulting claim determination by the Insurance Provider will be final. No additional appeals with respect to such claim will be available to you under the terms of the Life Insurance Plan.

The Insurance Provider's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- References to the specific Life Insurance Plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement describing any voluntary appeal procedures offered by the Life Insurance Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Special Rules for Disability Claim Determinations

Special rules apply if you have a claim that requires a determination that you are disabled by the Plan Administrator or the Insurance Provider. In that circumstance, the following rules apply.

Time Frame for Claim Determinations

The Insurance Provider will notify you of the adverse determination within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if the Insurance Provider both determines the extension is necessary due to matters beyond the control of the Life Insurance Plan, and notifies you, before the initial 45-day period expires, of the reason(s) requiring the extension of time and the date by which the Life Insurance Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Insurance Provider again determines that, due to matters beyond the control of the Life Insurance Plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days. In such case, the Insurance Provider must notify you, before the first 30-day extension period expires, of the reason(s) requiring the extension of time and the date by which the Life Insurance Plan expects to render a decision.

All extension notices you receive regarding your disability benefits must specifically explain:

- The standards on which entitlement to a benefit is based.
- The unresolved issues that prevent a decision on the claim.
- The additional information needed to resolve those issues.

You have 45 days to provide the specified additional information.

In the event that an extension is necessary due to your failure to submit necessary information, the Life Insurance Plan’s time frame for making a benefit determination is tolled (i.e., stopped) from the date the Insurance Provider sends you the extension notification until the date you respond to the request for additional information. If the Insurance Provider does not receive the requested information from you within the required period, your claim will be considered without such additional information and the resulting claim determination by the Insurance Provider will be final. No additional appeals with respect to such claim will be available to you under the terms of the Life Insurance Plan.

If You Receive an Adverse Benefit Determination

The Insurance Provider will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination.

- References to the specific Life Insurance Plan provisions on which the benefit determination is based.

- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.

- A description of the Life Insurance Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse determination.

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Life Insurance Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- An explanation of the basis for disagreeing with or not following (to the extent applicable) (A) the views presented by your health care professionals and vocational professionals who evaluated you, (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination, and (C) a disability determination made by the Social Security Administration.

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Life Insurance Plan do not exist, and

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (as defined above) to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:

  - Was relied upon in making the benefit determination.

Internal Use Only

- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
- Constitutes a statement of policy or guidance with respect to the Life Insurance Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

Procedures for Appealing an Adverse Benefit Determination

You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. In connection with an appeal, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination.
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination.
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination.
  - Constitutes a statement of policy or guidance with respect to the Life Insurance Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

Internal Use Only

- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate.
- If the appeal involves an adverse benefit determination based in whole or in part on a medical judgment, require the named fiduciary to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual.
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the decision.
- Receive, free of charge, any new or additional evidence considered, relied upon, or generated in making the benefit determination in connection with the claim, as well as any new or additional rationale, as soon as possible and sufficiently in advance of the notice on review to give you a reasonable opportunity to respond prior to that date.

The Insurance Provider must notify you of the Life Insurance Plan’s benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of your request for review by the Life Insurance Plan, unless the Insurance Provider determines that special circumstances require an extension of time. If an extension of time is required, a written notice of the extension must be sent to you before the end of the initial 45-day period. The notice of the extension must indicate the special circumstances and the date by which the Insurance Provider expects to render the determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the Life Insurance Plan’s time frame for making a benefit determination on review is stopped from the date the Insurance Provider sends you the extension notification until the date you respond to the request for additional information. If the Insurance Provider does not receive the requested information from you within the required period, your claim will be considered without such additional

information and the resulting claim determination by the Insurance Provider will be final. No additional appeals with respect to such claim will be available to you under the terms of the Life Insurance Plan.

The Insurance Provider's notice of an adverse benefit determination on appeal will contain all of the information that was included in the initial claim notice (described above), but it will also include the applicable contractual limitations imposed by the Life Insurance Plan that applies to the right to bring legal action following the appeal, including the calendar date on which such period expires.

You and your Life Insurance Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

If you reside in a county where 10% or more of the population is literate in a non-English language (as determined in accordance with data provided by the United States Census Bureau and the United States Department of Labor), the Life Insurance Plan will provide the following language assistance with respect to any claim relating to a determination of disability:

- Oral language services in the applicable non-English language for claims and appeals;
- Upon request, a notice in the applicable non-English language; and
- Provide in English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Life Insurance Plan.

If the Insurance Provider does not adhere to the federal requirements for handling disability claims and appeals, you will be deemed to have exhausted the claims and appeals procedure unless such failure was (1) de minimis; (2) nonprejudicial; (3) attributable to good cause or matters beyond the Life Insurance Plan's control; (4) in the context of an ongoing good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance. Upon written request, you are entitled to an explanation of the Life Insurance Plan's basis for asserting that it meets this standard within 10 days of the Insurance Provider's receipt of your request.

Internal Use Only

Exhaustion of Administrative Remedies and Limitations on Actions

If you do not agree with the Plan's final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable. You must use and fully exhaust all of your actual or potential rights under this Life Insurance Plan's administrative claims and appeals procedure by filing an initial claim and seeking a timely appeal of any adverse benefit determination before bringing suit or any other legal action against or with respect to the Plan and/or the Plan Administrator. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit or other legal action must be filed within the earliest of the following - (1) two years after receiving an adverse benefit determination on review or (2) two years of the date the claim arose. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying reimbursement request or benefit request is the final decision date. You must also comply with any requirements of the Insurance Provider. If the suit or other legal action does not relate to a claim for benefits, it must be brought within two years of the date you have actual or constructive knowledge of the claim. In addition, the suit or other legal action must only be brought or filed in a federal court in the Middle District of Florida. Failure to follow the Life Insurance Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination. This means that any claim, action or suit filed in court or in another tribunal will generally be dismissed.

In any action or consideration of a claim in court or in another tribunal following exhaustion of the Plan's claims procedures, the subsequent action or consideration shall be limited to the maximum extent permissible to the record that was before the Plan Administrator or Insurance Provider in the claims procedure process. Upon review by any court or other tribunal, the exhaustion requirement is intended to be interpreted to require exhaustion in as many circumstances as possible.

Discretionary Authority

The Plan Administrator and the Insurance Provider (with respect to all matters each such party is authorized to handle) have the exclusive discretionary authority to construe and to interpret the Life Insurance Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect.

Internal Use Only

Benefits under the Life Insurance Plan will be paid only if the Plan Administrator or the Insurance Provider, as applicable, decides in its discretion that a participant is entitled to them.

YOUR RIGHTS UNDER ERISA

As a participant in the Life Insurance 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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee 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, 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.

Enforce Your Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, you or your beneficiary has the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Internal Use Only

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Life Insurance Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court, but only after you have exhausted the plan's claims and appeals procedure, as described in the section "Claims and Appeals Process." If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Life Insurance Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Internal Use Only

NO GUARANTEE OF EMPLOYMENT

Your participation in, eligibility for or your right to benefits under the Life Insurance Plan described in this booklet is no guarantee of continued employment with Dun & Bradstreet or any Dun & Bradstreet company that participates in the Life Insurance Plan.

In accordance with ERISA, this booklet provides a summary plan description of the Life Insurance Plan, a part of The Dun & Bradstreet Corporation Welfare Benefit Plan. The information in this booklet does not constitute a commitment to continued employment.

Dun & Bradstreet reserves the right to change, modify or terminate any of the plans at any time.

Internal Use Only