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03/01/2009

GROUP BOOKLET-CERTIFICATE FOR MEMBERS:

MCCOY FEDERAL CREDIT UNION

ALL MEMBERS

Group Voluntary Term Life

Print Date: 07/30/2010

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Your insurance has been designed to provide financial help for you when a covered loss occurs. Your employer has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

The provisions of the Group Policy determine Members' rights and benefits. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

The effective date of your insurance is as shown on your Scheduled Benefits Summary and your enrollment form. You should keep your Scheduled Benefits Summary, enrollment form, any change of beneficiary or change of name forms, or other similar forms with your booklet after the form has been recorded by Us and returned to you.

NOTE: If this insurance replaces prior group life insurance provided through the Policyholder, the beneficiary named under the prior group life insurance and recorded by the Policyholder will be the beneficiary under the Group Policy unless you have named a new beneficiary. If you wish to change your beneficiary designation, you must complete a new beneficiary designation form - see the Policyholder for the necessary form.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. If you have any questions about this new booklet, please contact your employer. In the event of future changes to your insurance, you will be provided with a new Scheduled Benefits Summary, booklet-certificate, or a booklet-certificate rider.

If you have an electronic booklet, paper copies of this booklet-certificate are also available. Please contact your employer if you would like to request a paper copy.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

This booklet describes all the benefits available under the Group Policy underwritten by Us. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

The group insurance policy and your insurance under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

We reserve complete discretion to construe or interpret the provisions of this group insurance, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such matters will be controlling, binding, and final as between Us and persons insured by the Group Policy, subject to the Claim Procedures shown on GH 113 of this booklet.

ACCELERATED BENEFITS - Benefits paid as shown in this booklet-certificate for Accelerated Benefits are an advance of a portion of your Life Insurance benefit. This provision:

- accelerates and reduces your benefit;
- is not intended to be used as long-term care insurance.

Effect on Government Benefits. If you receive payment of Accelerated Benefits, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others.

Tax Consequences. Receiving Accelerated Benefits from the Group Policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive Accelerated Benefits from the Group Policy.

The insurance provided in this booklet is subject to the laws of the state of Florida.

Florida insurance law requires that each booklet-certificate include the telephone number of the insurance company issuing the policy in order for the persons to present inquiries, to obtain information about coverage, and to provide assistance in resolving complaints. Persons may call or write to:

Principal Life Insurance Company
711 High Street
Des Moines, Iowa 50392-0001

For Life claim-related inquiries:
Attn: Group Claim - Life Info Line Services
Telephone: 1-800-245-1522

For administration-related inquiries:
Attn: Group Call Center
Telephone: 1-800-843-1371

PRINCIPAL LIFE INSURANCE COMPANY
Des Moines, IA 50392-0001

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SUMMARY OF BENEFITS
(revised effective March 1, 2009)

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

MEMBER LIFE INSURANCE

If you die, your beneficiary will be paid the Scheduled Benefit then in force for you (however, see the exception noted below). Your specific Scheduled Benefit is shown on your Scheduled Benefits Summary and is based on your class:

Class	***Scheduled Benefit**
ALL MEMBERS	An amount in increments of $25,000 as applied for by you and approved by Us. The Maximum Scheduled Benefit amount will be $500,000 and the Minimum Scheduled Benefit amount will be $25,000, subject to the provisions below.

Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, and age changes, and receipt of an Accelerated Benefit payment.

*The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet on GH 110. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, the approved amount will be paid.

*If you are insured on the date the Group Policy is effective and this insurance replaces insurance in force on the day immediately before the effective date of the Group Policy, your initial Scheduled Benefit will only be for the amount of insurance for which you were insured under the Prior Policy.

For the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below.

Age	**% of Scheduled Benefit (or approved amount, whichever applies)**
Age 65 but less than age 70	65%
Age 70 and Over	50%

DEPENDENT LIFE INSURANCE

Unless a Beneficiary has been designated, if one of your Dependents dies, you will be paid the Scheduled Benefit (or approved amount, if applicable) then in force for that Dependent. The specific Scheduled Benefit is shown on your Scheduled Benefits Summary and is based on the status of your Dependent:

Class

ALL MEMBERS

Dependent	***Scheduled Benefit**

Spouse	An amount in increments of $5,000 as applied for by you and approved by Us. The Maximum Scheduled Benefit amount for your Dependent spouse will be $150,000 and the Minimum Scheduled Benefit amount for your Dependent spouse will be $5,000, subject to the provisions below.
Dependent Children (age at death)	
0 days old but less than 14 days	$1,000
14 days and older	$5,000
Dependent Children (age at death)	
0 days old but less than 14 days	$1,000
14 days and older	$10,000

*The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet on GH 111. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, the approved amount will be paid.

*If your Dependent is insured on the date the Group Policy is effective and this insurance replaces insurance in force on the day immediately before the effective date of the Group Policy, your Dependent's initial Scheduled Benefit will only be for the amount of insurance for which he or she was insured under the Prior Policy.

For the age(s) shown below, your Dependent spouse's amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below.

Age	**% of Scheduled Benefit (or approved amount, whichever applies)**
Age 65 but less than age 70	65%
Age 70 and Over	50%

In no event will a Dependent's Scheduled Benefit be more than 50% of your Scheduled Benefit amount. If you elect a Dependent Life benefit in excess of 50% of your Scheduled Benefit amount, the Dependent will be given the highest amount available, not to exceed 50%.

HOW TO BE INSURED - MEMBERS

MEMBER LIFE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

You will be eligible on the first of the Insurance Month coinciding with or next following the date you complete 30 consecutive days of continuous Active Work.

In no circumstance will you be eligible for Member Life Insurance under the Group Policy if you are eligible under any other Group Voluntary Term Life Insurance policy underwritten by Us.

Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for you if:

- you are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- you were Actively at Work on your last scheduled work day before the date of your absence; and
- you were capable of Active Work on the day before the scheduled effective date of your insurance or change in your insurance, whichever is applicable.

This Actively at Work requirement may also be waived as described below.

When insurance under the Group Policy replaces coverage under a Prior Policy, the Active Work requirement may be waived for those Members who:

- are eligible and enrolled under the Group Policy on the date the Group Policy is effective; and
- were covered under the Prior Policy on the date of its termination.

In no event will the Active Work requirement be waived for those Members who, on the date of termination of the Prior Policy, either:

- had the option, under the terms of the Prior Policy, to convert their coverage under the Prior Policy to an individual policy; or
- were eligible under the terms of the Prior Policy to have their premiums waived due to Total Disability.

NOTE: When insurance under the Group Policy replaces coverage under a Prior Policy and the Active Work requirement is waived, any benefits payable will be the lesser of the Scheduled Benefit of the Group Policy or the amount that would have been paid by the Prior Policy had it remained in force.

Individual Incontestability

All statements made by any insured person (you or one of your Dependents) will be representations and not warranties. These statements may not be used to contest an insured person’s insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and

- the statement is in Written form Signed by the insured person; and

- a copy of the form, which contains the statement, is given to the insured person or the insured person's beneficiary at the time insurance is contested.

In addition, if a person's age or sex is misstated, We may, at any time, adjust premium and benefits to reflect the correct age or sex.

Assignments

No assignments of Member Life Insurance will be allowed under the Group Policy.

Proof of Good Health

In some instances, Proof of Good Health will be required to place your insurance in force. We will determine the type and form of required proof. You will need to file Proof of Good Health:

- If you request insurance more than 31 days after the date you are eligible including any insurance you refuse and later request.

- If you request insurance under the Group Policy and you were eligible under the Prior Policy, but elected to waive coverage under the Prior Policy.

- If you have failed to provide required Proof of Good Health or you have been refused insurance under the Group Policy at any prior time.

- If you elect to terminate insurance and, more than 31 days later, you request to be insured again.

- *To make effective any Scheduled Benefit amounts for you that are, initially or through later increases, in excess of:

    - $100,000 if you are under age 70; and

    - $10,000 if you are age 70 or over.

    No Proof of Good Health is required for the initial excess amounts for Members insured on March 1, 2009.

    *If you are insured on the date the Group Policy is effective and this insurance replaces insurance in force on the day immediately before the effective date of the Group Policy: the lesser of the amount shown above or the amount for which you were insured under the replaced insurance.

- If less than 20% of the eligible employees participate or less than ten Members are insured, to make effective any Scheduled Benefit amount for you or your Dependents.

- To make effective any request for a Scheduled Benefit amount increase.

- To make effective any Scheduled Benefit amount increase in excess of 10% due to change in your Annual Compensation.

- To make effective any Scheduled Benefit amount increase if any previous Scheduled Benefit increase has been declined.

Effective Date for Initial Insurance
(Proof of Good Health Not Required)

You must request initial insurance in a form provided by Us.

Your insurance will normally be in force on:

- the date you are eligible, if you make your request on or before that date; or

- the first of the Insurance Month coinciding with or next following the date of your request, if you make your request within 31 days after the date you are eligible.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Initial Insurance
(Proof of Good Health Required)

If Proof of Good Health is required, your insurance will normally be in force on the later of:

- the date insurance would have been effective had Proof of Good Health not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

Effective Date for Benefit Changes Due to Change in Insurance Class

A change in your Scheduled Benefit amount because of a change in your insurance class for which Proof of Good Health is not required (see above) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are Actively at Work.

Any termination of Scheduled Benefit amounts due to a change in your insurance class will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to a change in your insurance class for which Proof of Good Health is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Effective Date for Benefit Changes Due to Changes by Policy Amendment

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109) by amendment to the Group Policy for which Proof of Good Health is not required (see above) will be effective on the date of change. However, if you are not Actively at Work on the date an increase in the Scheduled Benefit would otherwise be effective, the Scheduled Benefit in force will continue to apply to you until the day you return to Active Work. When you return to Active Work, the Scheduled Benefit increase will then be in force for you. Exception: Any decrease in Scheduled Benefit amounts due to a change by amendment to the Group Policy will be effective on the date of change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount because of a change in the Schedule of Insurance (as described on GH 109)

by amendment to the Group Policy for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Effective Date for Benefit Changes Due to Changes Requested by the Member

A change in your Scheduled Benefit amount due to your request for which Proof of Good Health is not required (see above), will be effective on the Policy Anniversary that next follows the date of the request. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts will be effective on the date of the change, whether or not you are Actively at Work.

A change in your Scheduled Benefit amount due to your request for which Proof of Good Health is required (see above), will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Effective Date for Benefit Changes Due to a Change in the Member's Family Status

You may request an increase in Scheduled Benefits, a decrease in Scheduled Benefits, or the addition of Scheduled Benefits for which you were not previously insured if a change in your family status as described below has occurred, provided a request for such increase, decrease, or addition is made in Writing within 31 days after the date of the change in family status:

- marriage or divorce;

- death of your spouse or child;

- birth or adoption of a child;

- termination of employment by your spouse or a change in your spouse's employment that causes loss of group insurance;

- your employment or your spouse's employment changes from part-time to full-time or from full-time to part-time;

- you or your spouse takes an unpaid leave of absence.

A change in the Scheduled Benefits because of a request by you when a change in family status has occurred for which Proof of Good Health is not required (see above) will normally be effective on the first of the Insurance Month coinciding with or next following the date of the request. However, if you are not Actively at Work on the date the Scheduled Benefit change would otherwise be effective, the Scheduled Benefit change will not be in force until the day you return to Active Work. Exception: Any decrease in Scheduled Benefit amounts due to your request, will be effective on the date of the change, whether or not you are Actively at Work.

A change in the Scheduled Benefits because of a request by you when a change in family status has occurred for which Proof of Good Health is required (see above) will be effective on the later of:

- the date the change would otherwise be effective if Proof of Good Health had not been required; or

- the first of the Insurance Month coinciding with or next following the date Proof of Good Health is approved by Us.

Termination

Your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the end of the Insurance Month for which the last premium is paid for your insurance; or
- the end of any Insurance Month, if requested by you before that date; or
- the end of the Insurance Month in which you cease to be a Member; or
- the end of the Insurance Month in which you cease to belong to a class for which insurance is provided; or
- the date you retire; or
- the end of the Insurance Month in which you cease Active Work.

Termination for Fraud

We may at any time terminate a person's eligibility under the Group Policy:

- in Writing and with 45-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law; or
- in Writing and with 45-day notice, upon finding in a civil or criminal case that an individual has submitted claims that contain false or fraudulent elements under state or federal law; or
- in Writing and with 45-day notice, when an individual has submitted a claim, which, in good faith judgment and investigation, an individual knew or should have known, contains false or fraudulent elements under state or federal law.

Insurance While Outside of the United States

If you or a Dependent are temporarily outside the United States, you or your Dependent may choose to continue insurance, subject to premium payment for a period of six months or less for one of the following reasons:

- travel; or
- a business assignment; or
- Full-Time Student status, provided you or your Dependent are either:
    - enrolled and attending an accredited school in a foreign country; or
    - participating in an academic program in a foreign country, for which the institution of higher learning at which you or your Dependent are enrolled in the U.S. grants academic credit.

The six-month period will not be reduced for any time covered under a Prior Policy.

If you or your Dependent are outside the United States for any other reason than those listed above, insurance for the person concerned will automatically terminate.

Continuation

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance.

If you cease Active Work because of layoff or leave of absence, insurance may be continued on a limited basis.

Your insurance may also be continued under the continuation provisions described on GH 118 and GH 118 A FL and subject to the provisions of the Group Policy.

Your insurance may also be continued under the Portability option described under GH 307 and subject to the provisions of the Group Life Portability Policy.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

HOW TO BE INSURED - DEPENDENTS

DEPENDENT LIFE INSURANCE

Eligibility

You will be eligible for insurance for your Dependents on the latest of:

- the date you are eligible for Member Life Insurance; or
- the date you first acquire a Dependent; or
- the date you enter a class for which Dependent Life Insurance is provided.

Effective Date

Dependent Life Insurance is available only with respect to Dependents of Members currently insured for Member Life Insurance. If a Member is eligible for Dependent Life Insurance, such insurance will be in force under the same terms as described earlier for Member insurance, except:

- In no event will Dependent Life Insurance be in force if you are not insured for Member Life Insurance.
- If a Dependent spouse is in a Period of Limited Activity on the date initial Dependent Life Insurance or an increase in Dependent Life Insurance Scheduled Benefit due to a change in your Annual Compensation or insurance class would otherwise be effective, the Dependent spouse will not be insured or an increase will not be effective until the Period of Limited Activity ends.

  However, this Period of Limited Activity requirement may be waived as described below.

  When insurance under the Group Policy replaces coverage under a Prior Policy, the Period of Limited Activity requirement may be waived for those Dependent spouses' who:

  - are eligible and enrolled under the Group Policy on the date the Group Policy is effective; and
  - were covered under the Prior Policy on the date of its termination.

  In no event will the Period of Limited Activity requirement be waived for those Dependent spouses' who, on the date of termination of the Prior Policy had the option, under the terms of the Prior Policy, to convert their coverage, under the Prior Policy, to an individual policy.

  NOTE: When insurance under the Group Policy replaces coverage under a Prior Policy and the Period of Limited activity requirement is waived any benefits payable will be the lesser of the Scheduled Benefit of the Group Policy or the amount that would have been paid by the Prior Policy had it remained in force.

- If you request insurance for a Dependent spouse under the Group Policy and the Dependent spouse was eligible under the Prior Policy, but elected to waive coverage under the Prior Policy.
- To make effective, any Scheduled Benefit amounts for your Dependent spouse that are initially, in excess of:
  - $30,000 for a person who is under age 70; and
  - $10,000 for a person who is age 70 or over.

Exception: No Proof of Good Health is required for the initial excess insurance for your Dependent spouse insured on March 1, 2009.

- If a Dependent is confined in a Hospital or Skilled Nursing Facility on the date an increase in Dependent Life Insurance Scheduled Benefits would otherwise be effective, the Scheduled Benefit in force for the Dependent will continue to apply to the Dependent until such confinement ends. When the Hospital or Skilled Nursing Facility confinement ends, the Scheduled Benefit increase will then be in force for the Dependent.

- Any required Proof of Good Health will be with respect to the health of your Dependents.

- If Dependent Life Insurance is then in force for any other Dependent, a new Dependent (other than a newborn child) will be insured on the date acquired, provided the new Dependent is not then confined in a Hospital or Skilled Nursing Facility. Requests for insurance and Proof of Good Health are not required provided We have been notified of the new Dependent within 31 days after the date the Dependent is acquired.

- If Dependent Life Insurance is then in force for any other Dependent, a newly born child will be insured from the moment of live birth, provided the child meets the definition of a Dependent Child.

Individual Incontestability

Your Dependents will be subject to the Individual Incontestability as described earlier for Member insurance.

Termination

Insurance for all of your Dependents will terminate on the earliest of:

- the date your Member Life Insurance ceases; or

- the date Dependent Life Insurance is removed from the Group Policy; or

- the end of the Insurance Month for which the last premium is paid for your Dependent’s insurance; or

- the end of any Insurance Month, if requested by you before that date; or

- the end of the Insurance Month in which you cease to belong to a class for which Dependent insurance is provided; or

- for Dependent Life , the date you retire; or

- the date you die.

Insurance for any one Dependent will terminate on the last day of the Insurance Month in which he or she ceases to be your Dependent.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

Termination for Fraud

Your Dependents will be subject to the Termination for Fraud provisions as described earlier for Member insurance.

Insurance While Outside of the United States

Your Dependents will be subject to the Insurance While Outside of the United States provisions as described earlier for Member insurance.

Continuation

Your Dependent's insurance may also be continued under the continuation provisions described on GH 118 and GH 118 A and subject to the provisions of the Group Policy.

Your Dependent's insurance may also be continued under the Portability option described on GH 307 and subject to the provisions of the Group Life Portability Policy.

CONTINUATION

Federal Family and Medical Leave Act (FMLA)

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your insurance, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";

- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or

- because of "qualifying exigency" arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to eligible employees to care for a "covered service member" with a "serious injury or illness".

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work and Period of Limited Activity requirements of the Group Policy.

Reinstatement of Insurance for you or your Dependent When Insurance Ends due to Living Outside of the United States

If insurance for you or your Dependent terminates because you or your Dependent are outside of the United States, you or your Dependent may become eligible again for insurance under the Group Policy, but only if:

- you or your Dependent return to the United States within six months of the date on which insurance terminated because the person is outside of the United States; and

- in your case, you return to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. You will be eligible for insurance on the day immediately following completion of the 30 consecutive days of Active Work; and

- in the case of your Dependent, he or she remains in the United States for 30 consecutive days. If your Dependent does so, he or she will be eligible for reinstatement of insurance on the day after completion of the 30 consecutive days of residence.

The reinstated insurance will be on the same basis as that being provided on the date insurance is reinstated. However, any restrictions on this insurance, which were in effect before reinstatement, will continue to apply. If you or your Dependent do not complete the 30 consecutive days of residence, the insurance for such person concerned will not be reinstated.

See your employer for details on this reinstatement provision.

CONTINUATION OF INSURANCE

Member (State Required - Florida)

If you cease Active Work because you are Totally Disabled, you may continue your Life Insurance until the earlier of:

- the date six months after the end of the Insurance Month in which your Total Disability began; or
- the date the Group Policy terminates.

If you are eligible for Member Life Insurance - Coverage During Disability as described in the Member Life Insurance Section, termination for any reason will not affect your rights to benefits, if any, for a Total Disability that begins while your insurance is in force under the plan.

Continuation (Extended Life Insurance)

If you are Totally Disabled on the date the Group Policy terminates, your Life Insurance may be continued until the earlier of:

- the date one year following the date of termination of the Group Policy; or
- the date of your death;

except that if you become Totally Disabled before the earlier of retirement or age 60, the Member Life Insurance - Coverage During Disability provisions as described in the Description of Benefits - Member Life Insurance Section, will apply to you. See your employer to make arrangements for continuing your coverage under the Extended Life Insurance provisions.

DESCRIPTION OF BENEFITS

MEMBER LIFE INSURANCE

Death Benefit

If you die while insured for Member Life Insurance, We will pay your beneficiary the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any Accelerated Benefit payment as discussed later in this section. If your beneficiary does not survive you, We will make payment in the following order of precedence:

- to your spouse;
- to your children born to or legally adopted by you;
- to your parents;
- to your brothers and sisters; or
- if none of the above, to the executor or administrator of your estate or other persons as provided in the Group Policy.

However, if a beneficiary is suspected or charged with your death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If a beneficiary is found guilty of your death, such beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent beneficiary or to the executor or administrator of your estate.

No payment will be made before We receive Written Proof of your death.

Upon your death, the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death, less any Accelerated Benefit payment as discussed later in this section will be placed in an interest-bearing draft account at an interest rate determined by Us, unless a lump sum or other settlement option has been elected. With the interest-bearing draft account, the balance will be available to your beneficiary at any time, in total or in part, as provided in the Group Policy.

See the Policyholder if you would like more information on the Interest Draft Account or on any of the other settlement options that are available to your beneficiary upon your death.

In the event the Interest Draft Account is not available or otherwise does not apply, We reserve the right to make payment of proceeds according to other settlement options if agreed to, in Writing, by Us.

If you die by suicide within 24 months after the effective date of your Member Life Insurance, We will pay your beneficiary the amount of any premium paid by you to Us during the period of time your insurance was in force in lieu of the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death. Any such payment will discharge Us to the full extent of such payment.

However, the 24 months may be reduced by any time satisfied under the Prior Policy, provided you were insured under the Prior Policy and coverage was in force for you on the date the Group Policy became effective.

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may name or later change your beneficiary by sending a Written request to Us. See the Policyholder for change request forms. A change in your beneficiary will not be in force until We record(s) the change. Once recorded, the change will apply as of the date the request was Signed. If We properly pay any benefit before a change request is received, that payment may not be contested.

Continuation (Member Life Insurance - Coverage During Disability)

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Totally Disabled, you might qualify to continue your Member Life Insurance and Dependent Life Insurance. This continuation is called Coverage During Disability. This Coverage During Disability provision does not apply to you if you have continued insurance under the Portability provision, as described on GH 307.

To be qualified for Coverage During Disability, you must:

- become Totally Disabled while insured for Member Life Insurance; and
- become Totally Disabled before age 60; and
- remain Totally Disabled continuously; and
- be under the regular care and attendance of a Physician; and
- send proof of Total Disability to Us within one year of the date Total Disability starts and as often thereafter as We may require; and
- return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, We will refund premiums paid, less dividends and less any outstanding policy loan balance; and
- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician).

If you qualify, Coverage During Disability will be in force on the earlier of:

- the day six months after the date your Total Disability began; or
- the date of your death.

Premium will not be charged for Member Life Insurance and Dependent Life Insurance while your Coverage During Disability is in force.

Coverage During Disability will cease on the earliest of:

- the date your Total Disability ends; or
- the date you fail to send Us any required proof of Total Disability; or
- the date you cease to be under the regular care and attendance of a Physician; or
- the date you fail to submit to a required Physician’s examination or evaluation by an evaluator; or
- the date you are age 65.

If you die while Coverage During Disability is in force, We will pay your beneficiary the Member Life Insurance benefit, if any, that would have been paid had you remained insured under the Schedule of Insurance in force on the date your Total Disability began. Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, and age changes, and receipt of an Accelerated Benefit payment.

Note that Coverage During Disability will not be in force and NO BENEFIT WILL BE PAID if Written proof of Total Disability is not sent to Us within ONE YEAR of the date Total Disability starts. However, failure to give Written proof within the time specified will not invalidate or reduce any claim if Written proof is given as soon as reasonably possible.

No benefits will be paid for any disability that:

- results from willful self-injury or self-destruction, while sane or insane; or
- results from war or act of war; or
- results from voluntary participation in an assault, felony, criminal activity, insurrection, or riot.

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of your Member Life Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for a Member Life Insurance benefit of at least $10,000; and
- be Terminally Ill (expected to die within 12 months); and
- send a request for Accelerated Benefit payment to Us; and
- send proof, satisfactory to Us, of your Terminal Illness.

Proof of Terminal Illness will consist of a statement from your Physician, and any other medical information that We believe is needed to confirm your status.

If you qualify, We will pay you any amount you request, except that:

- only one Accelerated Benefit payment will be made during your lifetime; and
- you must request a payment of at least $5,000; and
- We will not pay you more than the lesser of: (1) 75% of your Member Life Insurance benefit; or (2) $250,000.

We will pay you the Accelerated Benefit payment in a lump sum.

If an Accelerated Benefit is paid, the Member Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by any Accelerated Benefit payment.

Following is an EXAMPLE of how this benefit affects the final death benefit.

BENEFIT EXAMPLE		
Member Life Insurance Benefit Amount	$	100,000
Accelerated Benefit Amount Requested (Member would receive $75,000)	$	75,000
Payment to Member's Beneficiary ($100,000 - $75,000)	$	25,000

During the two-year period following payment of an Accelerated Benefit:

- termination of Active Work because of your Terminal Illness will not result in termination of your Member Life Insurance; and
- your Member Life Insurance and Dependent Life Insurance will be provided without premium charge.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting Proof of Good Health:

- If your total Member Life Insurance, or any portion of it, terminates because you end Active Work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may buy will be your Member Life Insurance amount in force on the date of termination or the portion of your Member Life Insurance that has terminated, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.

- If the Group Policy terminates or is amended to exclude your insurance class after you have been insured for at least five years. In these instances, the maximum amount you may buy will be the smaller of: (1) $10,000; or (2) your Member Life Insurance amount in force on the date of termination, less any Accelerated Benefit as discussed earlier in this Section and less any amount for which you become eligible under any group policy within 31 days.

- If your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount you may buy will be the Coverage During Disability benefit amount in force on the date Total Disability ends, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.

- If your Accelerated Benefit Premium Waiver Period ceases and you do not qualify for Coverage During Disability. In this instance, the maximum amount you may buy will be the Member Life Insurance benefit amount in force on the date you cease Active Work, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit as discussed earlier in this Section.

You must apply for individual purchase and pay the first premium to Us within 31 days after your insurance or Coverage During Disability under the Group Policy ceases.

See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong on the individual policy’s date of issue.

If you die within the 31-day purchase period, your beneficiary will be paid the life insurance amount, if any, you had the right to buy. This payment will be made whether or not you have applied for an individual policy.

DESCRIPTION OF BENEFITS

DEPENDENT LIFE INSURANCE

Death Benefit

If one of your Dependents dies while insured for Dependent Life Insurance, We will pay the Scheduled Benefit (or approved amount, if applicable) in force for that Dependent on the date of death, less any unpaid premium.

Unless a Beneficiary has been designated, payment will be to you if you survive the Dependent. If you do not survive the Dependent and a beneficiary for Dependent Life has not been named, We will pay the beneficiary you named for Member Life Insurance. However, if you are suspected or charged with your Dependent's death, the Death Benefits may be withheld until additional information has been received or the trial has been held. If you are found guilty of the Dependent's death, you may be disqualified from receiving any benefit due. Payment may then be made to the executor or administrator of the Dependent's estate.

No payment will be made before We receive Written proof of the Dependent's death.

If your Dependent dies by suicide within 24 months after the effective date of his or her Dependent Life Insurance, We will pay the amount of any premium, attributable to that Dependent, paid by you to Us during the period of time the Dependent Life Insurance for your Dependent was in force in lieu of the Scheduled Benefit (or approved amount, if applicable) in force on the date of your Dependent's death. Any such payment will discharge Us to the full extent of such payment.

However, the 24 months may be reduced by any time satisfied under the Prior Policy, provided your Dependent was insured under the Prior Policy and coverage was in force for your Dependent on the date the Group Policy became effective.

Beneficiary

You may name or later change the named beneficiary by sending a Written request to Us. A change will not be effective until recorded by Us. Once recorded, the change will apply as of the date the request was Signed. If We properly pay any benefit before a change request is received, that payment may not be contested.

Individual Purchase Rights

Your Dependent will have the right to buy an individual life insurance policy without submitting Proof of Good Health:

- If Dependent Life Insurance for your Dependent, or any portion of it, ceases because your Dependent ceases to qualify as a Dependent; or insurance terminates as described on GH 111, or you are divorced or separated, or because you die, end Active Work, or cease to be in a class eligible for insurance. In these instances, the maximum amount your Dependent may buy will be the amount of Dependent Life Insurance in force for the Dependent on the date of termination or the portion of Dependent Life Insurance that has terminated, less any individual amount purchased earlier under these rights.

- If the Group Policy terminates or is amended to eliminate Dependent Life Insurance or your insurance class after your Dependent has been insured for at least five years. In these instances, the maximum amount your Dependent may buy will be the smaller of: (1) $10,000; or (2) the amount of Dependent Life Insurance in force for the Dependent on the date of termination, less any amount for which the Dependent becomes eligible under any group policy within 31 days.

- If Dependent Life Insurance for your Dependent ceases because your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount your Dependent may buy will be the amount of Dependent Life

Insurance in force for the Dependent on the date of termination, less any individual amount purchased earlier under these rights.

- If Dependent Life Insurance for your Dependent ceases because your Accelerated Benefit Premium Waiver Period ceases and you do not qualify for Coverage During Disability. In this instance, the maximum amount your Dependent may buy will be the amount of Dependent Life Insurance in force for the Dependent on the date of termination, less any individual amount purchased earlier under these rights.

Your Dependent must apply for individual purchase and pay the first premium to Us within 31 days after the date his or her insurance under the Group Policy ceases. See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium to be paid will be at Our normal rate for your Dependent's age and risk class on the individual policy's date of issue.

If your Dependent dies within the 31-day purchase period, We will pay the life insurance amount, if any, the Dependent had the right to buy. This payment will be made whether or not your Dependent has applied for an individual policy.

DESCRIPTION OF BENEFITS

PORTABILITY

When insurance would otherwise end under the Group Policy as described below, you may be eligible to continue insurance under a Group Life Portability Insurance Policy underwritten by Us. The Group Life Portability Insurance Policy will contain provisions that differ from the Group Policy. If you elect to continue insurance under this option, you will receive a certificate outlining the Group Life Portability Insurance Policy provisions.

NOTE: You or your Dependent may elect to purchase an individual policy of life insurance (see Individual Purchase Rights as described on GH 203 and GH 305) in place of this portability option.

Member Life Insurance and Dependent Life Insurance

Eligibility

If Member Life Insurance and Dependent Life Insurance under the Group Policy ends because you cease to meet the definition of a Member, you may be eligible to continue such insurance under the Group Life Portability Insurance Policy without submitting Proof of Good Health.

In order to continue insurance under the Group Life Portability Insurance Policy:

- for Member Life Insurance, you must be less than age 75; and
- for Dependent Life Insurance, your Dependent spouse must be less than age 75; and
- for a Dependent Child, Member Life Insurance must be continued.

Insurance may not be continued under the Group Life Portability Insurance Policy if:

- your insurance has been continued under Coverage During Disability provisions described on GH 203; or
- you have received a benefit under Accelerated Benefits provisions described on GH 203; or
- your insurance under the Group Policy ends because the Group Policy terminates, and is replaced by another group voluntary policy; or
- you or your Dependent spouse have exercised your or your Dependent spouse’s Individual Purchase Rights described on GH 203; or
- your Dependent spouse ceased to be a Dependent as defined on GH 114; or
- you die.

Amount of Insurance

The insurance amount that is available for continuation will be the Member Life Insurance and Dependent Life Insurance Scheduled Benefit amount (or approved amount, if applicable) in force on the date insurance terminates under the Group Policy.

Termination of Ported Insurance

Ported insurance under the Group Life Portability Insurance Policy will terminate on the earliest of:

- the date ending the period for which the last premium is paid; or

- for Member insurance, the May 1 next following your 75th birthday; or

- for Dependent insurance for your Dependent spouse, the May 1 next following your Dependent spouse's 75th birthday; or

- for Dependent insurance, the date the insured person no longer qualifies as your Dependent, due to divorce or your death; or

- for Dependent insurance for your Dependent Child, the date the child no longer meets the definition of a Dependent Child as defined; or

- for Dependent insurance for a Dependent Child, the date Member Life Insurance ceases.

Note: When insurance under the Group Life Portability Insurance ends, you or your Dependent may qualify and elect to purchase an individual policy or life insurance.

Application/Effective Date

Notice of the Portability option must be given to you by the Policyholder before insurance under the Group Policy terminates, or as soon as reasonably possible thereafter.

When notice of eligibility to continue insurance under the Group Life Portability Insurance Policy is provided to Us within 60 days following the termination of insurance under the Group Policy, insurance will automatically be ported and become effective the day following termination of insurance under the Group Policy.

When notice of eligibility to continue insurance under the Group Life Portability Insurance Policy is not provided to Us following the termination of insurance under the Group Policy, you must apply for insurance and pay the first premium within 60 days of your termination date. Any continued insurance under the Portability option will be in force on the day following termination of insurance under the Group Policy.

Payment of premium constitutes your consent to port your insurance.

If you or your Dependent die(s) within the 60-day portability option period, We will pay the named beneficiary the Scheduled Benefit amount (or approved amount, if applicable) in force, if any, you or your Dependent had the right to continue. This payment will be made whether or not you have applied for the portability option.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 days after We receive such notice, you will be considered to have complied with the requirements of the Group Policy upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss or when reasonably possible. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employee Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the appropriate claim form is received by Us.

If it is not reasonably possible to give Written proof in the time required, We shall not reduce or deny a claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Payment, Denial, and Review

ERISA permits up to 45 days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a Written explanation prior to the expiration of the 45 days. A claimant is then allowed up to 45 days to provide all additional information requested. We are permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

In actual practice, benefits under the Group Policy will be payable sooner, provided We receive complete and proper proof of loss. Further, if a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for Our denial.

In addition, if a claim or a portion of a claim is contested by Us, the claimant or the claimant’s assignees will be notified, in Writing within 45 days after receipt of the claim, that the claim is contested or denied. The notice that a claim is contested will identify the contested portion of the claim and the reason for contesting the claim. Upon receipt of any requested additional information from the claimant or the claimant’s assignees, We will pay or deny the contested claim or portion of the contested claim within 60 days.

A claimant may request an appeal of a claim denial by Written request to Us within 180 days of the receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in Writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because We did not receive the requested additional information, We are permitted a 45-day extension for the review. Written notification will be sent to the claimant regarding the extension. After exhaustion of the formal appeal process, the claimant may request an additional appeal. However, this appeal is voluntary and does not need to be filed before asserting rights to legal action.

For purposes of this section, "claimant" means you, your Dependent, or Beneficiary.

Medical Examinations

We may have you or your Dependent, whose loss is the basis for claim, examined by a Physician during the course of a claim. We will pay for these examinations and will choose the Physician to perform them.

Autopsy

If payment for loss of life is claimed, We may require an autopsy. We will pay for any such autopsy.

Legal Action

Legal action to recover benefits under the Group Policy may not be started earlier than 90 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than the expiration of the applicable statute of limitations following the date proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this 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 and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon Written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about

this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

Several words and phrases used to describe your insurance are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

Active Work; Actively at Work mean you will be considered Actively at Work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered Active Work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Dependent means:

- Your spouse, if your spouse:
  - is legally married to you; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member.
- Your Dependent Child (or Children) as defined below.

Dependent Child; Dependent Children means:

- Your natural child, if that child:
  - is not married; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is less than 19 years of age.
- Your stepchild, if that child:
  - meets the requirements above; and
  - receives principal support from you.
- Your foster child, if that child:
  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is approved in Writing by Us as a Dependent Child.
- Your adopted child, if that child meets the requirements above and you:
  - are a party in a law suit in which you are seeking the adoption of the child; or

- have custody of the child under a court order that grants custody of the child to you.

An adopted child will be considered a Dependent Child on the earlier of: the date the petition for adoption is filed; or the date of entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

- The child of your Dependent Child, if the child can be claimed as your dependent for federal income tax purposes.

- Your child 19 years but less than 25 years of age who otherwise qualifies above, if that child receives principal support from you and is a Full-Time Student, as defined.

- Your child 19 years but less than 25 years of age, if that child is a Mormon missionary for a period of two years or less; and

  - otherwise qualifies above; and

  - receives principal support from you.

Developmental Disability means a Dependent Child's substantial handicap, as determined by Us, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

- is diagnosed by a Physician as a permanent or long-term continuing condition.

Full-Time Student means your Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria; and

- is dependent on you for principal support.

Group Policy means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members and Dependents.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Insurance Month means calendar month.

Member means any PERSON who is a full-time employee of the Policyholder and who regularly works at least 30 hours per week. The employee must be compensated by the Policyholder and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business, at an alternative worksite at the direction of the Policyholder, or at another place to which the employee must travel to perform his or her regular duties. This excludes any person who is scheduled to work for the Policyholder on a seasonal, temporary, contracted, or part-time basis.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder at least 30 hours per week and otherwise meets the definition of a Member.

Period of Limited Activity means any period of time during which a person is:

- confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or

- Home Confined. "Home Confined" means that, due to sickness or injury, the person is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical treatment.

Physical Handicap means a Dependent Child's substantial physical or mental impairment, as determined by Us, which:

- results from injury, accident, congenital defect or sickness; and

- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or

- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

The term Physician does not include you, one of your employees, your business or professional partner or associate, any person who has a financial affiliation or business interest with you, anyone related to you by blood or marriage, or anyone living in your household.

Policyholder means MCCOY FEDERAL CREDIT UNION.

Prior Policy means the Group Voluntary Term Life coverage of either:

- the Policyholder; or

- a business entity which has been obtained by the Policyholder through a merger or acquisition;

for which the Group Policy is a replacement.

Proof of Good Health means Written evidence that a person is insurable under Our underwriting standards. This proof must be provided in a form satisfactory to Us.

Qualifying Event means for Accelerated Benefits, a medical condition, which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, BUT ARE NOT LIMITED TO, one or more of the following:

- coronary artery disease resulting in an acute infarction or requiring surgery;

- permanent neurological deficit resulting from cerebral vascular accident;

- end stage renal failure; or

- acquired immune deficiency syndrome (AIDS).

Scheduled Benefits Summary means the page, which is issued as part of your certificate that contains benefit and other information pertaining to your insurance under the Group Policy.

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by Us.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and

- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and

- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and

- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places for treatment of mental disease, drug addiction, or alcoholism.

Terminally Ill means, for Accelerated Benefits, you have experienced a Qualifying Event and you are expected to die within 12 months of the date you request payment of Accelerated Benefits.

Total Disability; Totally Disabled means for you, your inability, due to sickness or injury, to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training or experience.

We, Us, and Our means Principal Life Insurance Company, Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

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PLAN ARRANGED BY

RENAISSANCE BENEFIT ADVISORS
6450 KINGSPOINTE PKWY
ORLANDO FL
32819

Principal Life Insurance Company
Des Moines, Iowa 50392-0002