If you have any questions regarding your group insurance plan, please send your correspondence to:

AIG Benefit Solutions
PO Box 30066
Tampa, FL 33630-3066

Policy issued by:

American General Life Insurance Company
Houston, Texas

The United States Life Insurance Company in the City of New York
New York, New York

New York, New York

AIG Benefit Solutions® is the marketing name for the domestic benefits division of American International Group, Inc.

The underwriting risks, financial and contractual obligations and support functions associated with products issued by American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, Pa. are the issuing insurer’s responsibility. The United States Life Insurance Company in the City of New York and National Union Fire Insurance Company of Pittsburgh, Pa. are authorized to conduct insurance business in New York. Policies are not available in all states.
The Company will pay the benefits of this policy subject to its provisions. This page and the pages that follow are part of this policy.

Group policy no.: 40G620

Policyholder: SAINT LOUIS UNIVERSITY

PREMIUM PAYMENTS

This policy is issued in return for the payment by the Policyholder of required premiums. Premiums are payable at the home office of the Company or to its authorized agent. The first premium is due on the effective date of this policy. Later premiums are due monthly in advance on the first day of each month. These dates are the premium due dates.

EFFECTIVE DATE

This policy will take effect on January 1, 2014.

POLICY ANNIVERSARIES

Policy anniversaries will be January 1, 2015 and each subsequent January 1.

APPLICABLE LAW

This policy is issued in and governed by the laws of Missouri.

The President and Secretary of the Company witness this policy.

CEO & President

Secretary

Registrar

Signed by:________________________________________
(A licensed resident agent where required by law)

GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE POLICY
# POLICY INDEX

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face Page ..................................................</td>
<td>1</td>
</tr>
<tr>
<td>Index ...........................................................</td>
<td>2</td>
</tr>
<tr>
<td>Incorporation Provisions ..................................</td>
<td>3</td>
</tr>
<tr>
<td>Premiums</td>
<td></td>
</tr>
<tr>
<td>Frequency of Premium Payment</td>
<td>4</td>
</tr>
<tr>
<td>Right To Change Premium Rates</td>
<td>4</td>
</tr>
<tr>
<td>Premium For Changes In Insurance</td>
<td>4</td>
</tr>
<tr>
<td>Experience Rating</td>
<td>4</td>
</tr>
<tr>
<td>Insurance Premium Rates</td>
<td>4</td>
</tr>
<tr>
<td>End of Insurance Provided by this Policy</td>
<td></td>
</tr>
<tr>
<td>Ways Insurance May End</td>
<td>5</td>
</tr>
<tr>
<td>If Insurance Ends - Premiums</td>
<td>5</td>
</tr>
<tr>
<td>Reinstatement</td>
<td>5</td>
</tr>
<tr>
<td>General Provisions</td>
<td></td>
</tr>
<tr>
<td>The Contract</td>
<td>6</td>
</tr>
<tr>
<td>Agency</td>
<td>6</td>
</tr>
<tr>
<td>Certificates</td>
<td>6</td>
</tr>
<tr>
<td>Compliance with Law</td>
<td>6</td>
</tr>
<tr>
<td>Clerical Error</td>
<td>6</td>
</tr>
<tr>
<td>Data Needed</td>
<td>6</td>
</tr>
<tr>
<td>Incontestability</td>
<td>7</td>
</tr>
<tr>
<td>Interpretation Of The Policy</td>
<td>7</td>
</tr>
<tr>
<td>Limit on Agent's Authority</td>
<td>7</td>
</tr>
<tr>
<td>New Entrants</td>
<td>7</td>
</tr>
<tr>
<td>Policy Non-Participating</td>
<td>7</td>
</tr>
<tr>
<td>Time Period</td>
<td>7</td>
</tr>
</tbody>
</table>
INCORPORATION PROVISIONS

1. From the effective date of the policy, changes in the following items will be made a part of this policy:
   a. the name of the Policyholder;
   b. the premium rates;
   c. amounts of insurance, eligibility, benefit descriptions, or any other provisions incorporated into the policy.

2. Any change in item "1" above will be given on the Company's forms.

3. The effective date of incorporation of a provision or another change that affects the insurance of any person insured under this policy will be the later of:
   a. the effective date of this policy;
   b. the date of any amendment to this policy that changes the Company's obligation to pay benefits under this policy.

4. All of the benefits and provisions in an Insured Person's certificate of insurance issued under this policy are made a part of this policy.
PREMIUMS

FREQUENCY OF PREMIUM PAYMENT

Premiums for this policy are payable monthly in advance. The Policyholder and the Company may agree that payment be made in advance every 3, 6 or 12 months.

RIGHT TO CHANGE PREMIUM RATES

The Company may change premium rates on any date on or after the third policy anniversary. The Company will notify the Policyholder in writing, at least 31 days before such change. However, the Company may change premium rates at any time, if a change occurs that has a direct bearing on the risk the Company assumed, including:

- the date this policy is amended
- the date a division, subsidiary, affiliated company or an eligible class is added to or deleted from this policy
- a 10% increase or decrease in the number of insured employees
- a material misstatement in the reported experience during the pre-sale process
- when any federal or state law or regulation is enacted, promulgated, amended or clarified to the extent that it affects the Company's benefit obligation.

The new premium will apply only to premiums due on or after the date the rate change takes effect.

PREMIUM FOR CHANGES IN INSURANCE

If any insurance is added, increased or becomes effective after this policy is in force, the premium charges will begin on the next scheduled bill date.

For insurance which is decreased or terminated, premium charges will be adjusted as of the next scheduled bill date.

EXPERIENCE RATING

If the policy is experienced rated, any credit amount due the Policyholder will be credited on the policy anniversary date and, at the Policyholder's request will be:

- paid in cash; or
- used to reduce premiums; or
- used to provide additional insurance for insured employees.

Any credit amount will be determined by the rating plan or plans used by the Company.

INSURANCE PREMIUM RATES

The premium rates in effect on the effective date are those determined by the Company. Those rates will be shown on the billing notice(s) sent to the Policyholder.
END OF INSURANCE PROVIDED BY THIS POLICY

WAYS INSURANCE MAY END

By The Company:

Except for fraudulent misrepresentation or non-payment of premium, the Company may not end insurance under this policy prior to the first policy anniversary.

The Company can end insurance under this policy for any reason by giving 30 days advance written notice to the Policyholder.

The Company can end insurance under this policy immediately, in the event of fraudulent misrepresentation by the Policyholder.

The Company can end insurance under this policy for non-payment of premium.

Each premium after the first may be paid up to 31 days after its due date. This period is the grace period. The Company has the right to suspend payment of claims incurred during the grace period. The Company will not be responsible for claims incurred during any period for which full premium has not been paid.

If premiums for the next premium due date are not paid in full by the Policyholder during the grace period, insurance will end on the day immediately following the last day of the coverage period for which the required premium has been paid.

Premiums for this policy may be paid in separate bills covering categories of employees set up by the Policyholder. If premium is not paid for a category of employees, the Company can end insurance for such employees as set forth above.

By The Policyholder:

The Policyholder can end insurance under this policy by giving 30 days advance written notice to the Company.

Notification:

If insurance under this policy ends for any reason, the Policyholder will notify the insured persons of such termination.

IF INSURANCE ENDS - PREMIUMS

If insurance ends, all premiums due must be paid. Such payment will be on a pro rata basis for any period that this policy was in effect from the date the last premium was paid. If the Company accepts premium after the date this policy ends, this will not act to "reinstate" the policy. The Company will refund any unearned premium.

REINSTATEMENT

To reinstate this policy, the Policyholder must complete the required form and send it to the Company along with the required premium. If this request is approved, this policy will be reinstated on the date stated in writing by the Company. If this request is not approved, all unearned premiums will be returned.
GENERAL PROVISIONS

THE CONTRACT

The entire contract is made up of these items:

- the policy, including the certificate which then applies to each insured class
- the Policyholder's application, a copy of which is attached, and
- the applications and/or enrollment forms of the individual insureds.

All statements made by the Policyholder are representations and not warranties.

This policy may be changed at any time by a written agreement between the Policyholder and the Company. The provisions of this policy may be changed only by a Company executive officer and then only in writing.

AGENCY

The Policyholder is not the Company's agent for any purpose under this policy.

CERTIFICATES

The Company will issue certificates to the Policyholder. The Policyholder must give a certificate to each insured employee. Such certificates will describe such person's benefits and rights under this policy.

COMPLIANCE WITH LAW

On the date this policy takes effect, some of its provisions may conflict with an applicable law. If so, any such provision is changed to comply with the minimums required by such law.

CLERICAL ERROR

A clerical error may be made by the Company or the Policyholder in keeping the data. If so, when the error is found the premium and/or benefits will be adjusted according to the correct data. An error will not end insurance validly in force, nor will it continue insurance validly ended.

DATA NEEDED

The Policyholder will keep a record of all the data needed to compute premiums and carry out the terms of this policy. The Company can examine such data at any reasonable time.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.
INCONTESTABILITY

Of this policy

The Company will not contest this policy after it has been in force for 2 years from its effective date (or date of last reinstatement), except for non-payment of premiums or fraudulent misrepresentation.

Of a person’s insurance

The Company will not use a person’s statements relating to insurability to contest insurance after it has been in force for 2 years during the person’s life, except for non-payment of premium or fraudulent misrepresentation. Such 2-year period begins on the person’s effective date of coverage and excludes any period during which such person was disabled. The Company will also not use such statement, except fraudulent statements, to contest an increase or benefit addition to the person’s insurance after the increase or benefit addition has been in force for 2 years during such person’s life. Such 2-year period begins on the person’s effective date of the increase or benefit addition and excludes any period during which such person was disabled.

These statements must be in writing on a form satisfactory to the Company and signed by the person. A copy of this form will be given to the person.

The Company can only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Insured Person or the Insured Person’s beneficiary.

INTERPRETATION OF THE POLICY

This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

If this policy comprises a part of an employee benefits plan, the Company is granted the sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of this policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this policy or any other plan of benefits.

LIMIT ON AGENT’S AUTHORITY

No agent is authorized to change or waive any provision of the policy. Any change must be approved in writing by an officer of the Company.

NEW ENTRANTS

New persons may be insured according to the terms of this policy.

POLICY NON-PARTICIPATING

The policy does not pay dividends.

TIME PERIOD

For purposes of effective dates and ending dates under this policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.
The following section applies only to those persons who are eligible for and have enrolled in the Group Term Life and AD&D Plan.
If you have any questions regarding your group insurance plan, please send your correspondence to:

AIG Benefit Solutions
PO Box 30066
Tampa, FL 33630-3066

Policy issued by:

American General Life Insurance Company
Houston, Texas

The United States Life Insurance Company in the City of New York
New York, New York

New York, New York

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CERTIFICATE OF INSURANCE

American General Life Insurance Company (the Company) certifies that certain eligible persons are insured for the benefits described in this certificate. This insurance is subject to the eligibility and effective date requirements described in the ELIGIBILITY section of this certificate.

IMPORTANT NOTICE

This certificate is a summary of the group policy provisions that affect your insurance. It is merely evidence of the insurance provided by such policy for SAINT LOUIS UNIVERSITY (the Policyholder).

The group policy is a contract between the Company and the Policyholder. It may be changed or ended without notice to or consent of any insured person.

This certificate replaces any certificate previously issued by the Company to you under the group policy.

The benefits described in this certificate are provided by group policy no. 40G620.

The Company is providing this electronic version of the certificate at the request of the Policyholder. The Policyholder maintains the group policy, which includes a copy of the certificate. The group policy is available for you to review and copy. If there is any conflict between the information in this electronic version of the certificate and the group policy, the group policy will control in all respects.

PLEASE READ THIS CERTIFICATE CAREFULLY
CERTIFICATE INDEX

<table>
<thead>
<tr>
<th>Section I  Definitions</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section II  Eligibility</td>
<td></td>
</tr>
<tr>
<td>Eligible Classes</td>
<td>10</td>
</tr>
<tr>
<td>Eligibility</td>
<td>10</td>
</tr>
<tr>
<td>Insured's Effective Date</td>
<td>10</td>
</tr>
<tr>
<td>Late Entrants</td>
<td>10</td>
</tr>
<tr>
<td>Change in Family Status</td>
<td>11</td>
</tr>
<tr>
<td>Evidence of Insurability Requirement</td>
<td>11</td>
</tr>
<tr>
<td>Actively At Work Requirement</td>
<td>11</td>
</tr>
<tr>
<td>Dependent Eligibility</td>
<td>11</td>
</tr>
<tr>
<td>Insured Dependent's Effective Date</td>
<td>11</td>
</tr>
<tr>
<td>Effective Date of Changes</td>
<td>12</td>
</tr>
<tr>
<td>No Loss/No Gain</td>
<td>12</td>
</tr>
<tr>
<td>Section III  Date Insurance Ends</td>
<td></td>
</tr>
<tr>
<td>Insured's Termination Date</td>
<td>13</td>
</tr>
<tr>
<td>Insured Dependent's Termination Date</td>
<td>13</td>
</tr>
<tr>
<td>Reinstatement of Insurance</td>
<td>13</td>
</tr>
<tr>
<td>Exceptions to Termination of Insurance</td>
<td>14</td>
</tr>
<tr>
<td>Suspension of Coverage During Military Service</td>
<td>14</td>
</tr>
<tr>
<td>Continuation of Coverage While on Leave under the Family and Medical Leave Act</td>
<td>14</td>
</tr>
<tr>
<td>Section IV  Benefits</td>
<td></td>
</tr>
<tr>
<td>Life Insurance</td>
<td></td>
</tr>
<tr>
<td>Death Benefit</td>
<td>14</td>
</tr>
<tr>
<td>Reduction Schedule</td>
<td>15</td>
</tr>
<tr>
<td>Extension of Life Insurance</td>
<td>15</td>
</tr>
<tr>
<td>Conversion Privilege</td>
<td>16</td>
</tr>
<tr>
<td>Portability</td>
<td>17</td>
</tr>
<tr>
<td>Accelerated Life Insurance Benefit</td>
<td>18</td>
</tr>
<tr>
<td>Limitations</td>
<td>19</td>
</tr>
<tr>
<td>Dependent Life Insurance</td>
<td>19</td>
</tr>
<tr>
<td>Conversion Privilege</td>
<td>19</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Insurance</td>
<td></td>
</tr>
<tr>
<td>Accidental Death Benefit</td>
<td>21</td>
</tr>
<tr>
<td>Accidental Dismemberment Benefit</td>
<td>21</td>
</tr>
<tr>
<td>Day Care Benefit</td>
<td>21</td>
</tr>
<tr>
<td>Exposure and Disappearance</td>
<td>22</td>
</tr>
<tr>
<td>Limitation on Multiple Benefits</td>
<td>22</td>
</tr>
<tr>
<td>Repatriation of Remains Benefit</td>
<td>22</td>
</tr>
<tr>
<td>Seat Belt and Air Bag Benefit</td>
<td>23</td>
</tr>
<tr>
<td>Tuition Benefit</td>
<td>23</td>
</tr>
<tr>
<td>Permanent Total Disability Benefit</td>
<td>24</td>
</tr>
<tr>
<td>Exclusions</td>
<td>25</td>
</tr>
<tr>
<td>Section V  Claims Provisions</td>
<td></td>
</tr>
<tr>
<td>Section VI  General Provisions</td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE OF BENEFITS

Eligible Class(es):

Class 1 – All active full-time employees as defined in the Eligible Classes provision in the ELIGIBILITY section

FULL-TIME means active work on the Policyholder’s regular work schedule for the class of employees to which you belong. The work schedule must be at least 32 hours a week.

Policy Effective Date: January 1, 2014
Policy Anniversary Date: January 1, 2015, and each subsequent January 1

Waiting Period:

Present Eligible Persons.........................................The first day of the month following the date he or she enters an eligible class

Future Eligible Persons...........................................The first day of the month following the date he or she enters an eligible class

LIFE INSURANCE

Basic Life Insurance

Basic Life Insurance Benefit Amount........................................ An amount equal to the Insured's Basic Earnings, rounded to the next higher $1,000 multiple, if not one already, with a minimum of $10,000

Basic Life Insurance Maximum.............................................$400,000

Basic Guaranteed Issue Amount.............................................$400,000

Supplemental Life Insurance

Supplemental Life Insurance Benefit Amount...................... An amount equal to one, two or three times the Employee's Basic Earnings, rounded to the next higher $1,000 multiple, if not one already, which when combined with the Basic amount does not exceed $400,000

Supplemental Life Insurance Maximum.............................................$400,000

Supplemental Life Insurance Guaranteed Issue Amount ....... The lesser of: $400,000, or an amount equal to the three times the Employee's Basic Earnings
SCHEDULE OF BENEFITS

Supplemental Dependent Life Insurance

Supplemental Life Insurance Benefit Amount
Insured Spouse ......................................................................................................................... $25,000
Spouse Maximum Amount ........................................................................................................... $25,000
Spouse Guaranteed Issue Amount ................................................................................................. $25,000

Insured Dependent Children
Birth to 19 years ......................................................................................................................... $12,500

Full-time student
19 years to 26 years .................................................................................................................... $12,500
Child Guaranteed Issue Amount ................................................................................................. $12,500

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) Benefit

AD&D Principal Sum ...................................................................................................................... An amount equal to the Insured’s Basic Earnings, rounded to the next higher $1,000 multiple, if not one already, with a minimum of $10,000
AD&D Insurance Maximum ........................................................................................................ $600,000

Basic Life Insurance Reduction Schedule
50% of the scheduled amount at age 70

Supplemental Life Insurance Reduction Schedule
50% of the scheduled amount at age 70

AD&D Insurance Reduction Schedule
65% of the scheduled amount at age 70
45% of the scheduled amount at age 75
30% of the scheduled amount at age 80
20% of the scheduled amount at age 85
Section I DEFINITIONS

ACCIDENT means an unexpected and undesirable event or occurrence that is sudden, unforeseen and unintended.

ACTIVE WORK/ACTIVELY AT WORK means performing normal duties for the Policyholder at the usual place of employment, an alternative work site at the direction of the Policyholder, or at a location to which the Policyholder requires the Insured to travel. An Insured will be considered Actively At Work on each regularly scheduled non-work day if he or she was Actively At Work on the immediately preceding scheduled work day, provided the Insured is not Totally Disabled.

ACTIVITIES OF DAILY LIVING (ADL) means the following activities:

- Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;
- Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility - the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and
- Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

AUTOMOBILE means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

BASIC EARNINGS means the Insured’s annual compensation from the Policyholder.

Basic earnings includes:

- the Insured’s average monthly compensation from the Policyholder during the Policyholder’s prior tax year if the Insured was a Partner, Professional Corporation (P.C.) Partner, Owner-employee, Sole Proprietor and/or S-Corporation Shareholder;
- the average annual compensation received by the Insured’s professional corporation from the Policyholder during the Policyholder’s prior tax year. The Company will calculate annual earnings by adding the following items as reported on the applicable Schedule K-1, Schedule C, Form W-2, or S-Corporation federal income tax return, or by the number of months that the Insured was a Partner, Professional Corporation (P.C.) Partner, Owner-employee, Sole Proprietor and/or S-Corporation Shareholder if less than 12 months. This includes the Insured’s:
  - ordinary income from trade or business activities;
  - guaranteed payments if he or she was a Partner;
  - net profit from the business;
  - compensation (as an officer), salary or wages, if he or she was a S-Corporation Shareholder.
Section I DEFINITIONS

- the Insured’s average annual rate of compensation from the Policyholder including:
  - average annual salary
  - regular hourly wages (but not for more than 40 hours a week)
  - commissions averaged over the preceding 24 months or the period of the Insured’s employment if less than 24 months
- shift differential pay
- contributions the Insured makes through a salary reduction agreement with the Policyholder to:
  - an Internal Revenue Code (IRC) 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement;
  - an executive nonqualified deferral compensation arrangement
- amounts contributed to the Insured’s fringe benefits according to a salary reduction agreement under an IRC section 125 plan.

Basic earnings does not include:

- bonuses
- overtime pay
- extra compensation
- the Policyholder’s contributions on the Insured’s behalf to any deferred compensation plan or pension plan
- income the Insured earns as a private contractor on IRS form 1099
- stock options

CHANGE IN FAMILY STATUS means:

- an Insured’s marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
- the death of or divorce from an Insured’s spouse;
- the death of or emancipation of a child;
- Spouse’s loss of employment which results in a loss of group insurance; or
- change in classification from part-time to full-time or from full-time to part-time.

COGNITIVE IMPAIRMENT means that the Insured has been certified by a Physician as having a deterioration or loss in intellectual capacity, resulting from Injury, Sickness, Alzheimer’s disease or similar forms of irreversible dementia, and the Insured needs another person’s active help or verbal guidance for his or her own protection and the protection of others.

DAY CARE CENTER means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction.
DEPENDENT CHILD(REN) means the Insured’s unmarried children, including natural, step, foster or adopted children from the moment of placement in the home of the Insured, under age 19, (19 - 26 if attending an accredited Institution of Higher Learning on a full time basis) and primarily dependent on the Insured for support and maintenance.

Any unmarried Dependent Children of the Insured covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured for support and maintenance, may continue to be eligible under the Policy beyond that age limit as long as the Policy is in force, but only if they remain continuously covered under the Policy. The Company may request that the Insured submit satisfactory proof of the Dependent Child(ren)'s incapacity and dependency to the Company within 60 days before the Dependent Child(ren) reach the age limit specified above. If the Insured fails to furnish the requested proof before the Dependent Child(ren) reach the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the Company may request that the Insured submit satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency to the Company on an annual basis.

If the Insured fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child(ren) will terminate at the end of that 31-day period.

EVIDENCE OF INSURABILITY means a statement or proof of a person’s medical history upon which acceptance for insurance will be determined by the Company.

FAMILY COVERAGE means coverage in force under the Policy on an Insured’s Eligible Dependents: (1) whom the Insured has elected to cover under the Policy; and (2) for whom premium has been paid.

GUARANTEED ISSUE AMOUNT means the amount of insurance that will be issued to an Insured Person without Evidence of Insurability. The Guaranteed Issue Amount for an Insured Person’s Life Insurance is shown in the Schedule. For amounts in excess of the Guaranteed Issue Amount, Evidence of Insurability satisfactory to the Company may be provided at the Insured’s expense.

IMMEDIATE FAMILY MEMBER means a person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted, stepchild, or foster child), aunt, uncle, niece, nephew, or grandchild.

INJURY means bodily injury that is the direct result of an Accident occurring while the Policy is in force with respect to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a covered loss.

INSTITUTION OF HIGHER LEARNING means any accredited institution that provides education or training beyond the 12th grade level, including, but not limited to, any state university, private college, or trade school.

INSURED means a person who is a member of an Eligible Class for whom premium has been paid while covered under the Policy.

INSURED DEPENDENT means an Insured Dependent Child or an Insured Spouse, for whom premium is paid while covered under the Policy.

INSURED DEPENDENT CHILD means the Insured’s Dependent Child, for whom premium is paid while covered under the Policy.

INSURED PERSON means the Insured or an Insured Dependent.
Section I

DEFINITIONS

INSURED SPOUSE means the Insured's Spouse, for whom premium is paid while covered under this Policy.

LOSS OF A HAND OR FOOT means complete severance through or above the wrist or ankle joint.

LOSS OF SIGHT OF AN EYE means total and irrecoverable loss of the entire sight in that eye.

MILITARY means the armed land, sea or air force of a nation.

PARAMILITARY means an organized, armed force on a Military pattern.

PERMANENTLY TOTALLY DISABLED/PERMANENT TOTAL DISABILITY means that the Insured is permanently unable to perform the material and substantial duties of the Insured's regular occupation for the initial benefit period of 12 months and following that period any occupation for which he or she is qualified by reason of education, experience or training.

PHYSICIAN means a licensed practitioner of the healing arts acting within the scope of his or her license, who is not: (a) the Insured Person; (b) an Immediate Family Member; (c) residing with the Insured Person; or (d) retained by the Policyholder.

PRIOR PLAN means the Group Life Insurance and Accidental Death and Dismemberment Insurance carried by the Policyholder on the day before the Policy Effective Date.

SCHEDULE means the Schedule of Benefits section of the Policy.

SICKNESS means illness or disease diagnosed by a Physician.

SPOUSE means the Insured’s lawful spouse (not including a spouse who is legally separated from the Insured).

SUPPLEMENTAL RESTRAINT SYSTEM means an air bag which inflates for added protection to the head and chest areas.

TOTAL DISABILITY/TOTALLY DISABLED means that, as a result of Injury or Sickness, the Insured is unable to perform the material and substantial duties of the Insured's regular occupation for the initial benefit period of 12 months and following that period any occupation for which he or she is reasonably qualified by education, training or experience.

WAR OR INSURRECTION means an armed conflict between the Military or Paramilitary forces of two (2) or more political entities.
Section II  ELIGIBILITY

Eligible Classes

All active full-time employees who are:

- Faculty and Staff,
- House Staff,
- Covered by a collective bargaining agreement between the employer and the International Union of Operating Engineers Local 148,
- Medical Faculty with a full-time joint appointment with the Veterans Administration whose compensation by St. Louis University exceeds $5,000 per year and who also meets the St. Louis University joint hours and budgeting requirements,

and who are United States citizens working in the United States, United States citizens working abroad for a period of up to 12 months, or any other employees as agreed upon between the Policyholder and the Company

but not those who are:

- Living and working in a county subject to a sanctions program administered by the United States Treasury Office of Foreign Asset Control,
- Not meeting our Underwriting criteria, as determined by the Company,
- Temporary, part-time or seasonal

Eligibility. Before becoming eligible for coverage under the Policy, a Waiting Period must be satisfied by each member of an Eligible Class as shown in the Schedule.

Insured’s Effective Date. An Insured’s coverage under the Policy will become effective on the latest of the following dates:

If Non-Contributory

1. the Policy Effective Date; or

2. the first day of the month following the date the person becomes eligible for insurance;

If Contributory

1. the first day of the month following the date the person applies for insurance, if such date is within 31 days of his or her eligibility date;

2. the first day of the month following the date the Company approves the application for insurance and any required Evidence of Insurability, if application is made more than 31 days after his or her eligibility date;

3. the date for which the first premium for the person’s coverage is paid; or

4. the Policy Effective Date.

Late Entrants

The following limitations will apply to a later enrollment: If the person does not enroll within 31 days after becoming eligible, he or she may only apply for coverage within 31 days of a Change in Family Status. The date that the person is insured will be the first day of the month following the date the Company approves application for insurance and any required Evidence of Insurability.
Section II ELIGIBILITY

Change in Family Status

A Change in Family Status means:

1. An Insured’s marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
2. The death of or divorce from an Insured’s spouse;
3. The death of or emancipation of a child;
4. Spouse’s loss of employment which results in a loss of group insurance; or
5. Change in classification from part-time to full-time or from full-time to part-time.

The Insured will be allowed to enroll or increase one increment if a Change in Family Status applies.

Evidence of Insurability Requirement

Evidence of insurability is required if the person:

- is a late applicant, which means that he or she requests insurance more than 31 days after the date he or she is eligible;
- voluntarily canceled his or her insurance and is reapplying;
- applies after any of his or her coverage ended because he or she did not pay a required contribution, or
- has not met a previous Evidence of Insurability requirement to become insured under any plan the Policyholder has with the Company.

Any Life Insurance which is in excess of the Guaranteed Issue Amount or is subject to Evidence of Insurability shall become effective on the date the Company approves evidence that the person is insurable, subject to any applicable waiting period.

Actively At Work Requirement

If the person is not Actively at Work on the date his or her insurance would otherwise become effective, insurance will not be effective until the date such person returns to and remains Actively at Work.

Dependent Eligibility. An Insured’s Dependents are eligible for Dependent Life Insurance benefits under the Policy on the day the Insured becomes eligible for dependent coverage. However a Dependent can only be either an Insured or a Dependent under the same policy, not both.

Insured Dependent’s Effective Date. An Insured Dependent’s coverage under the Policy will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the Insured’s effective date of insurance;
3. the date for which the first premium for the person’s coverage is paid;
4. the date the Insured elects dependent coverage under the Policy; or
5. the date the Company approves the application for insurance and any required Evidence of Insurability, if application is made more than 31 days after the dependent’s eligibility date.
Section II  ELIGIBILITY

Any Life Insurance which is in excess of the Guaranteed Issue Amount or is subject to Evidence of Insurability shall become effective on the date the Company approves evidence that the person is insurable, subject to any applicable waiting period.

If the person is unable to engage in the normal activities of a person in good health of like age and sex on the date the insurance would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex.

Effective Date of Changes. Any change in the amount of an Insured’s insurance due to a change in Basic Earnings will take effect on the Policy Anniversary Date immediately following the date of such change. Any change in the amount of an Insured’s insurance due to his or her becoming a member of another Eligible Class will take effect on the Policy Anniversary Date immediately following the date of such change.

If the Insured is not Actively at Work on the date that an increase in his or her coverage is to take effect, such increase will be effective on the date the Insured returns to Active Work.

If an Insured Dependent is unable to engage in the activities of a person in good health of like age and sex on the date an increase in his or her Dependent Life Insurance Benefit Amount would otherwise become effective, such increase will not be effective until the date such Insured Dependent is able to engage in normal activities of a person in good health of like age and sex.

No Loss / No Gain

If a person is absent from work due to a physical or mental condition on the date his or her insurance would otherwise have become effective, the effective date of the person’s insurance will be deferred until the date he or she returns to Active Work.

If the person was insured under the Prior Plan on the day before the Policy Effective Date and would be eligible for coverage on the Policy Effective Date; except that he or she is not able to meet the requirements of Actively at Work; then the coverage amount shown in the Schedule of Insurance will not apply to such person.

Instead, the person will be considered to be insured and the Company’s coverage amount will be the lesser of:

1. the amount of Life Insurance and Accidental Death and Dismemberment Insurance under the Prior Plan; or

2. the amount of Life Insurance and Accidental Death and Dismemberment Insurance shown in the Schedule of Insurance, reduced by any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan.

The person will remain insured under this provision until the first to occur of:

1. the date he or she returns to Active Work;

2. the date his or her insurance terminates for a reason stated under the termination provision;

3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or

4. the last day the person would have been covered under the Prior Plan, had the Prior Plan not terminated.
Section III  DATE INSURANCE ENDS

**Insured’s Termination Date.** An Insured’s coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the grace period);
2. at the end of the month following the date the Insured ceases to be a member of an Eligible Class;
3. the date the Policy terminates; or
4. the date the Insured notifies the Company in writing to discontinue his or her coverage.

With respect to Accidental Death and Dismemberment Insurance, termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from an accident that occurred while the Insured’s coverage was in force under the Policy.

**Insured Dependent’s Termination Date.** An Insured Dependent’s coverage under the Policy ends on the earliest of the following dates:

1. at the end of the month following the date the Insured’s coverage under the Policy ends;
2. at the end of the month following the date the person ceases to qualify as an Insured Dependent;
3. the premium due date, if premiums are not paid when due (subject to the grace period);
4. at the end of the month following the date the Insured is no longer eligible for dependent coverage;
5. the date dependent coverage is no longer provided by the Policy;
6. the date the Insured notifies the Company in writing to discontinue his or her dependent coverage;
7. the date the coverage terminates; or
8. the date the Policy terminates.

**Reinstatement of Insurance.** If insurance ends because the Insured ceases to be eligible for coverage as defined in this Certificate, coverage may be reinstated and no additional waiting period will apply if, within six months after the date the insurance ends, the Insured becomes a member of an Eligible Class. If insurance ends because of default in payment on the part of the Insured, coverage may be reinstated at any time within 5 years after date of default upon presentation of evidence of insurability satisfactory to the Company and payment of all premiums in arrears.
Exceptions to Termination of Insurance. If the Insured terminates Active Work and if premium payments for his or her coverage are made when due, he or she may be considered to be Actively at Work, subject to the conditions set forth below.

1. If the Insured terminates Active Work due to temporary lay off or leave of absence, coverage may be continued until the earliest of the following dates:
   a. the date the Policyholder ceases to pay the Insured's premiums, or otherwise terminates the insurance; or
   b. 31 days from the date the Insured ceases to be Actively at Work; or
   c. the date the Policy terminates.

2. If the Insured terminates Active Work due to Injury or Sickness, coverage under the Policy may be continued in accordance with the Extension of Life Insurance provision. However, if the insured is not eligible for continuance under the Extension of Life Insurance Provision and is no longer Actively at Work due to injury or Sickness, then the longest they can be covered is for 12 months unless age 65 or older.

Suspension of Coverage During Military Service

The Company will suspend the Insured's insurance on the date he or she goes on active duty in the Military service of any country or international authority. Such duty will not include temporary active duty by reservists for military training that lasts 90 days or less. The Company will refund that part of any premium paid for the period of such suspension.

A person can place his or her insurance back in force without Evidence of Insurability or earned income as of the date of his or her discharge. To do so, he or she must apply in writing and pay the premium, both within 90 days after active duty ends.

The Company will base the person's premium on his or her age and class of risk when such person's insurance was suspended. If the person was disabled on or before the date of discharge, he or she must have recovered for at least 6 months before the Company will cover a later disability from the same cause.

Continuation of Coverage While on Leave under the Family and Medical Leave Act

If an Insured is eligible for and the Policyholder approves a leave of absence under the Federal Family and Medical Leave Act of 1993 (FMLA) or any similar state law, his or her insurance will continue for a period of up to 12 weeks following the date the leave begins provided the Policyholder pays the required premiums in accordance with the provisions of the group policy. The Company may require written confirmation of the FMLA approval from the Policyholder.

The Insured is eligible for leave under this act in order to provide care:

- after the birth of a child
- after the legal adoption of a child
- after the placement of a foster child in his or her home
- to a spouse, child or parent due to their serious illness, or
- for the Insured's own serious health condition.

If the Insured does not continue his or her insurance during the FMLA leave, upon his or her return to active employment:

- no new waiting period will be applied
- no new pre-existing conditions exclusions or limitations will be applied, and
- no Evidence of Insurability will be required to reinstate the insurance in effect before the leave began.
LIFE INSURANCE

Death Benefit. Upon receipt of due proof of death, the Company will pay the Life Insurance Benefit Amount(s) in force on the Insured’s life at the time of his or her death, in accordance with the terms of the Policy. In no event will the total amount of Life Insurance in force for an Insured exceed the Life Insurance Maximum shown in the Schedule.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.

Reduction Schedule. The Basic and Supplemental Life Insurance Benefit Amount(s) payable with respect to an Insured Person will be reduced to the Percentage of Scheduled Benefit when the Insured Person attains the ages shown in the Schedule. The Accidental Death and Dismemberment Insurance benefits payable with respect to an Insured Person will be reduced to the Percentage of Scheduled Benefit if the Insured Person has attained the ages shown in the Schedule on the date of the accident causing the loss.

These reductions will also apply to any insurance that is extended in accordance with the Extension of Life Insurance provision in this Policy. Any decrease in the amount of insurance due to age will take place on the Insured Person’s birthday.

"Age" as used above refers to the age of the Insured Person on his or her most recent birthday, regardless of the actual time of birth.

"Scheduled Benefit" as used above refers to the applicable benefit amount shown in the Schedule that would otherwise be payable in the absence of any benefit reduction.

Extension of Life Insurance

Waiver of Premium Benefit. If the Insured becomes Totally Disabled before reaching age 60, his or her Basic and Supplemental Life Insurance under this Policy will continue for one year from the date the Insured becomes Totally Disabled, provided that the Insured remains Totally Disabled, and premiums are paid when due. The Life Insurance benefit will be the same amount for which the Insured would have been eligible if he or she were not Totally Disabled, subject to any applicable benefit reduction. Insurance may be continued beyond such one-year period, provided:

1. the Insured furnishes proof satisfactory to the Company, at least 180 days from the date such Total Disability began, that the Insured has been Totally Disabled continuously from the date the Total Disability began; and

2. such proof is furnished to the Company no later than one year after the date the Total Disability begins.

Upon submission of the required proof, premiums paid on the Insured’s behalf during the Total Disability will be refunded. The Company will waive the required premium payments until the Insured is no longer Totally Disabled, provided the Insured: (a) furnishes proof that the Total Disability has continued uninterrupted; and (b) submits to a physical exam when required, as provided below.
Section IV  
BENEFITS

Benefits will end on the earliest of the following dates:

1. the date the Insured ceases to be Totally Disabled;
2. the date the Insured fails to submit to a physical exam as required;
3. the date the Insured’s Life Insurance would otherwise terminate as indicated in the Policy;
4. the date proof of Total Disability is not provided when due; or
5. the date the Insured reaches age 70.

If the Insured ceases to be Totally Disabled, premiums must be paid when due if insurance coverage is to be continued.

Physical Exam. The Company will have the right to have a Physician of its choice examine the Insured to establish any disability. The Company will pay for the exam. The Insured may be examined as often as reasonably necessary during the period of disability, but not more than once a year after he or she has been disabled for two years.

Conversion After Extension. When any applicable extension of benefits described in this section ends, the Insured may convert his or her coverage to an individual insurance policy, provided the Insured is Entitled to Convert as described in the Conversion Privilege provision.

Conversion Privilege

The Insured may convert his or her Life Insurance under the Policy to an individual policy if such insurance, or any portion of it, ends, provided the Insured is Entitled to Convert and, within 31 days after such insurance ends the Insured:

1. applies in writing to the Company at P.O. Box 30066, Tampa, Florida 33630-3066; and
2. pays the first premium.

Evidence of Insurability. No Evidence of Insurability will be required if the Insured converts to an individual policy under this Conversion Privilege.

Entitled to Convert. The Insured is Entitled to Convert his or her Life Insurance only if:

1. the Insured ceases to be a member of an Eligible Class as described in the Eligible Class(es) section of the Schedule;
2. the Policy terminates, provided the Insured has been covered under the Policy for at least five consecutive years immediately preceding such termination;
3. the Policy is amended to terminate the Eligible Class to which the Insured belongs, provided he or she has been covered under the Policy for at least five consecutive years immediately preceding such termination;
4. the employment of the Insured terminates.

In no event will the Insured be Entitled to Convert if his or her coverage under the Policy ceases due to non-payment of the required premium.
Amount of Converted Life Insurance. If the Insured’s coverage terminates because he or she is no longer a member of an Eligible Class, the amount of Life Insurance that he or she will be eligible to convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Insured’s Life Insurance ends because the Policy is amended to terminate the Eligible Class to which he or she belongs, or if the Policy terminates or the employment of the Insured terminates, the amount of Life Insurance under the converted life policy will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time insurance ends; or (b) $10,000.

Type of Policy. The individual policy will be the Company’s current offering and will be on a form customarily issued by the Company. However, such policy may not be term insurance. No disability or other supplemental benefits will be covered under the policy. The individual policy will go into effect at the end of the period during which the Insured is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the policy can be contested, such time periods will be deemed to have begun at the time the Insured was first covered under the Policy.

The premium will be based on the Company’s rates for the individual policy form, the benefit amount, age and the class of risk to which the Insured belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

Death During the Conversion Period. If the Insured dies within the 31-day conversion period, the Company will pay a death benefit equal to the maximum amount the Insured could have otherwise converted.

Notice of Conversion Right. Notice of the Insured’s right to convert to an individual policy will be presented to the Insured or delivered to the Insured’s last known address within 15 days from the date his or her coverage ends. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.

Portability

In lieu of the Conversion Privilege stated above, if the Insured ceases to be a member of an Eligible Class for any reason other than retirement, the Insured may elect to convert his/her Supplemental Life Insurance to another Group Policy offered by the Company or an affiliate of the Company provided he or she has not attained age 70. The Insured may also elect to continue Dependent Life Insurance on his or her Insured Dependent Spouse provided the Insured Dependent Spouse has not attained age 70. The Insured must: (a) make such election within 31 days of termination of eligibility, and (b) agree to pay the entire premium for such coverage.

This coverage will be subject to all of the provisions and limitations of the Portability Policy, including reductions for age or termination at age 70. Premium rates for coverage under the Portability Policy will be based on the Insured’s age, sex and smoking status at the time of election of this option and at renewal. Coverage provided under this provision will end when the Portability Policy terminates but will continue through the last period for which premiums have been paid. Premiums for this coverage will be billed directly to the Insured on a quarterly, semi-annual or annual basis, as elected by the Insured.

The Portability Policy will contain a right to convert the Insured’s coverage to an individual policy offered by American General Life Insurance Company or an affiliate of the Company.
Section IV BENEFITS

Accelerated Life Insurance Benefit

If elected by the Insured, and subject to approval by the Company, a portion of the Insured’s Life Insurance benefit may be paid before his or her death. To qualify for this benefit, the Insured must have been diagnosed as being terminally ill while insured under this Policy or must meet the qualifying conditions stated below. The Insured must apply for Accelerated Life Insurance benefits in writing on a form acceptable to the Company.

Qualifying Conditions

To qualify for this benefit, the Insured must: 1) be unable to continuously perform one or more Activities of Daily Living (ADL), without stand by help; 2) have a Cognitive Impairment; or 3) have a terminal illness.

Any activity of daily living the Insured is not able to perform, without stand by help, prior to the effective date of coverage will not be considered for qualifying for this benefit. Any Cognitive Impairments due to, caused by, or contributed by a cognitive condition that began prior to the effective date of coverage will not be considered for qualifying for this benefit.

Proof of Terminal Illness. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Company that the Insured’s life expectancy is 6 months or less from the date of application for this benefit. Proof of terminal illness must include certification from a Physician. The Company reserves the right to obtain a second or third medical opinion at its own expense.

Proof of other Qualifying Conditions. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Company that the person meets the qualifying conditions. Proof must be certified by a Physician and in the form that is satisfactory to the Company. The Company reserves the right to obtain a second or third medical opinion at its own expense.

Benefit Amount

The maximum benefit the Insured may receive under this provision is the lesser of:

1. 75% of the Insured’s Life Insurance benefit shown in the Schedule, including any Supplemental Life Insurance benefit less the amount of any benefit already paid under this provision; or

2. $250,000.

However if the Insured’s Life Insurance is scheduled to reduce within 6 months of the date application for this benefit is received by the Company, the Accelerated Life Insurance Benefit will be limited to the amount that would be available for accelerated payment after such reduction takes place.

The minimum Accelerated Life Insurance benefit the Insured may receive will be $1,000. Such benefit will be paid in a lump sum to the Insured, unless an alternate payment arrangement is requested by the Insured in writing and is approved by the Company. However, the minimum payment under such installment payment arrangement will be $500 per payment.

The receipt of this Accelerated Life Insurance benefit may be taxable. The Insured should seek assistance from a personal tax advisor with respect to receipt of this benefit. No representations as to any issue of taxation of this benefit are made by the Company.

Effect on Life Insurance Benefits at Insured’s Death. The Insured’s Life Insurance Benefit Amount(s) shown in the Schedule will be reduced by any amount paid under this provision.
Section IV BENEFITS

Termination of Accelerated Life Insurance Benefits. This benefit will terminate on the date the Insured’s insurance under the Policy terminates. However, this benefit will continue to be available while the Insured is covered under the Extension of Life Insurance provision of the Policy.

Limitations. The Company will not provide benefits under this provision if:

1. the Insured would be required by law to use the benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
2. the Insured is required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement;
3. the Insured’s Life Insurance under the Policy has terminated;
4. each irrevocable beneficiary, if any, has disapproved payment of this benefit; or
5. the Insured’s Life Insurance benefits under the Policy have been assigned.
6. the Insured's terminal illness is the result of intentional self-inflicted injury or attempted suicide while sane.

Payees. Benefits will be paid in one lump sum to the insured, if living. If not living the Company may pay such benefits to the Insured's estate.

The Company will not be liable for such payment after it is made.

DEPENDENT LIFE INSURANCE

Death Benefit. Upon receipt of due proof of death, the Company will pay the Life Insurance Benefit Amount(s) in force on the Insured Dependent’s life at the time of his or her death, in accordance with the terms of the Policy. In no event will the total amount of Life Insurance in force for an Insured Dependent exceed the Life Insurance Maximum shown in the Schedule.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.

Conversion Privilege

An Insured Dependent may convert his or her Dependent Life Insurance under the Policy to an individual policy if such person’s insurance, or any portion of it, ends, provided the individual is Entitled to Convert and, within 31 days after such insurance ends he or she:

1. applies in writing to the Company at P.O. Box 30066, Tampa, Florida 33630-3066; and
2. pays the first premium.

Evidence of Insurability. No Evidence of Insurability will be required for an Insured Dependent who converts to an individual policy under the Conversion Privilege.
Entitled to Convert. An Insured Dependent is Entitled to Convert his or her Life Insurance only if:

1. the Insured ceases to be a member of an Eligible Class as described in the Eligible Class(es) section of the Schedule;

2. the Insured dies;

3. the person ceases to qualify for coverage as an Insured Dependent, as defined in the Policy;

4. the Policy terminates, provided: (a) the Insured is Entitled to Convert; and (b) the Insured Dependent has been covered under the Policy for at least five consecutive years immediately preceding such termination;

5. the Policy is amended to terminate the Eligible Class to which the Insured belongs, provided: (a) the Insured is Entitled to Convert; and (b) the Insured Dependent has been covered under the Policy for at least five consecutive years immediately preceding such termination; or

6. the employment of the Insured terminates.

Amount of Converted Life Insurance. If the Insured Dependent ceases to be eligible for insurance under the Policy, the amount of Life Insurance he or she will be Entitled to Convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Insured Dependent’s Life Insurance ends because the Policy is amended to terminate the Eligible Class to which the Insured belongs or the employment of the Insured terminates, or if the Policy terminates, the amount of Life Insurance the Insured Dependent will be Entitled to Convert will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time his or her insurance ends, less any amount for which he or she becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000.

Type of Policy. The individual Policy will be the Company’s current offering and will be on a form customarily issued by the Company. However, such Policy may not be term insurance. No disability or other supplemental benefits will be covered under the policy. The individual policy will go into effect at the end of the period during which the Insured Dependent is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the policy can be contested, such time periods will be deemed to have begun at the time the Insured Dependent was first covered under the Policy.

The premium will be based on the Company’s rates for the individual policy form, the benefit amount, age and the class of risk to which the insured belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

Death During the Conversion Period. If the Insured Dependent dies within the 31-day conversion period, the Company will pay a death benefit equal to the maximum amount he or she could have otherwise converted.

Notice of Conversion Right. Notice of the Insured Dependent’s right to convert to an individual policy will be presented to him or her or delivered to the individual’s last known address within 15 days. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.
Section IV  BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS AND COVERAGE

Principal Sum. As applicable to each Insured, Principal Sum means the amount(s) of insurance in force under this Policy on the date of the accident, as described in the Schedule. In no event will the total amount of Accidental Death and Dismemberment Insurance in force for an Insured exceed the AD&D Insurance Maximum shown in the Schedule.

As applicable to an Insured Dependent, Principal Sum means the amount of insurance in force under the Policy as described in the Schedule.

Accidental Death Benefit

If Injury to the Insured Person results in death within 365 days of the date of the Accident that caused the Injury, the Company will pay 100% of the Principal Sum.

Accidental Dismemberment Benefit

If Injury to the Insured Person results, within 365 days of the date of the Accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Principal Sum shown below for that Loss:

For Loss of                                    Percentage of Principal Sum
Both Hands or Both Feet ................................................................. 100%
Sight of Both Eyes ................................................................. 100%
One Hand and One Foot ................................................................. 100%
One Hand and the Sight of One Eye ................................. 100%
One Foot and the Sight of One Eye ................................................................. 100%
One Hand or One Foot ................................................................. 50%
Sight of One Eye................................................................. 50%

If more than one Loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

Day Care Benefit

If an Insured suffers accidental death such that an Accidental Death benefit is payable under the Policy on the date of the accident causing death, the Company will pay a benefit on behalf of any Dependent Child under age 13 who: (1) is enrolled in a Day Care Center on the date of the Insured’s death; or (2) enrolls in a Day Care Center within 365 days after the Insured's death. The benefit is payable for each year of the Dependent Child’s enrollment in a Day Care Center. The total amount of the benefit each year is equal to the least of:

1. the actual cost of care for that Dependent Child charged by that Day Care Center for that year;
2. 5% (in 1% increments to 10% and then 5% increments to the maximum) of the Insured's Principal Sum on the date of the accident causing death; or
3. $2,500 (in $1,000 increments to $10,000 and then $5,000 increments to the maximum).

The applicable portion of the yearly benefit for each period of enrollment is payable upon receipt of due proof of enrollment, but not more frequently than monthly.
Section IV BENEFITS

The benefit is not payable for any period of enrollment in a Day Care Center before the date of the accident that caused the Insured’s death. The benefit is not payable for any period of enrollment after the earlier of: (1) the date the Dependent Child reaches 13 years of age; or (2) the date four (4) years after the later of the date of the Insured’s death or the date the Dependent Child first enrolls in a Day Care Center.

Exposure and Disappearance

If by reason of an accident occurring while an Insured Person's coverage is in force under the Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Person has suffered accidental death within the meaning of the Policy.

Limitation on Multiple Benefits

If an Insured Person suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits provided under the Policy, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit or Permanent Total Disability Benefit.

Repatriation of Remains Benefit

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, the Company will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $5,000 (in $5,000 increments to $100,000 and then in $25,000 increments to the maximum).

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

AIG Benefits Travel AssistSM must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AIG Benefits Travel AssistSM in advance.

Exclusion 2 in the Exclusions section of the Accidental Death and Dismemberment Benefit provision in this Certificate does not apply with respect to this benefit.
Section IV BENEFITS

Seat Belt and Air Bag Benefit

Seat Belt Benefit. If the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the Accident causing death occurs while the Insured Person is operating, or riding as a passenger in, an Automobile and wearing a properly fastened, original, factory-installed seat belt or, if the person is a Dependent Child, a properly installed and fastened child restraint device as defined by state law, the Company will pay this additional benefit. The amount payable for this additional benefit is $10,000.

Air Bag Benefit. If a Seat Belt Benefit is payable and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the Company will pay an additional $10,000.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

Tuition Benefit

If an Insured suffers accidental death such that an Accidental Death benefit is payable under the Policy on the date of the Accident causing death, the Company will pay the following benefit:

A. For the Dependent Children under Age 23. The Company will pay a benefit to or on behalf of any Dependent Child under age 23 who was insured under the Policy on the date of the Accident causing death and who, on the date of the Insured's death: (1) is a full-time student in any Institution of Higher Learning above grade 12; or (2) is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Insured's death. The benefit will be paid for each year of the Dependent Child’s continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of four (4) consecutive years. The total amount of the benefit each year is equal to the least of:

1. the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Dependent Child;

2. 5% of the Insured's Principal Sum on the date of the Accident causing death; or

3. $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Insured’s death. If there is no Dependent Child under age 23 eligible for the benefit within 365 days after the date of the Insured’s death, the Company will pay a one-time lump sum benefit of 1000 to the Insured's designated beneficiary.
Section IV  

**BENEFITS**

**B. For the Insured Spouse.** The *Company* will pay a benefit to or on behalf of any Spouse on the date of the Accident causing death and who, for the purpose of obtaining an independent source of support or to enrich his or her ability to earn a living: (1) is enrolled in any Institution of Higher Learning or professional or trade training program on the date of the Insured's death; or (2) subsequently enrolls in an Institution of Higher Learning or professional or trade training program within 30 months after the date of the Insured's death. The benefit will be paid for each year of the Spouse's continuous enrollment in an Institution of Higher Learning or professional or trade training program, to a maximum of four (4) consecutive years. The total amount of the benefit for all institutions and programs combined each year is equal to the least of:

1. the total actual tuition (exclusive of room and board) charged by those institutions or programs for enrollment during that year for the Spouse;

2. 5% of the Insured's Principal Sum on the date of the Accident causing death; or

3. $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A Spouse who ceases to be enrolled as described above becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment that begins before the date of the Insured's death. If there is no Spouse eligible for the benefit within 30 months after the date of the Insured’s death, the *Company* will pay a one-time lump sum benefit of $1,000 to the Insured’s designated beneficiary.

**Permanent Total Disability Benefit (Not Applicable to Insureds Age 70 or Older on the Date of the Accident)**

If Injury renders an Insured Permanently Totally Disabled within 365 days of the Accident that caused the Injury, and if the Permanent Total Disability due to that Injury continues for a period of 12 consecutive months, the *Company* will pay a monthly benefit of 1% of the Principal Sum, starting with the 13th consecutive month of Permanent Total Disability. The benefit is payable monthly as long as the Insured remains continuously Permanently Totally Disabled due to that Injury, but ceases on the earliest of: (1) the date the Insured ceases to be Permanently Totally Disabled due to that Injury; (2) the date the Insured dies; or (3) the date the total amount of monthly Permanent Total Disability benefits paid for all Injuries caused by the same Accident equals 100% of the Principal Sum. The *Company* will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the *Company* is liable when the Insured is Permanently Totally Disabled for less than a full month. Only one benefit is provided for any one month of Permanent Total Disability, regardless of the number of Injuries causing the Permanent Total Disability.

The *Company* reserves the right, at the end of the first 12 consecutive months of Permanent Total Disability (and as often as it may reasonably require thereafter) to determine, on the basis of all the facts and circumstances, that the Insured is Permanently Totally Disabled, including, but not limited to, requiring an independent medical examination provided at the expense of the *Company*. 
EXCLUSIONS

The Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at intentionally self-inflicted injury while sane (SEE STATEMENT BELOW);
2. sickness, disease or infections of any kind, except bacterial infections or pyogenic infections;
3. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation on a regular schedule between established airports, if the Insured Person is:
   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or by the Insured Person's employer;
4. declared or undeclared War, or any act of declared or undeclared War;
5. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);
6. the Insured Person being under the influence of drugs or under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a Physician; or
7. the Insured Person's commission of or attempt to commit a crime.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.
Section V CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after an Insured Person’s loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at 3600 Route 66, Neptune, New Jersey, 07753, with information sufficient to identify the Insured Person, is deemed notice to the Company. This provision applies to accidental death and dismemberment coverage only.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 31 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured Person's name, Policyholder's name and the Policy number. This provision applies to accidental death and dismemberment coverage only.

Proof of Loss. Written proof of loss must be furnished to the Company within 90 days after the date of loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proof within the time required, will not reduce or deny any benefits if the proof is given as soon as reasonably possible. However, in no event, other than legal incapacity, will proof be given more than one year after the date of loss. This provision applies to accidental death and dismemberment coverage only.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured will be made to the Insured’s beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured. If an Insured dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Company may make an initial payment, up to an amount not exceeding $2,000, to any relative by blood or connection by marriage of the payee who is deemed by the Company to be equitably entitled thereto. Such payment does not discharge the Company’s liability for any remaining benefits payable under the Policy.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the Company’s receipt of due written proof of the loss. Subject to the Company’s receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.
Section VI  GENERAL PROVISIONS

Entire Contract; Changes. The Policy, the Master Application, and any attached papers make up the entire contract between Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured will be used in any contest unless a copy of the statement is furnished to the Insured or his or her beneficiary or personal representative.

No change in the Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent may change the Policy or any of its provisions.

Incontestability. The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium or fraudulent misrepresentation.

After an Insured Person has been covered under the Policy for two years no statement made by the Insured Person will be used to contest a claim under the Policy. The Company can only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the Insured Person's beneficiary.

Interpretation of the Policy. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

If this policy comprises a part of an employee benefits plan, the Company is granted the sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of this policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this policy or any other plan of benefits.

Beneficiary Designation and Change. The Insured’s designated beneficiary(ies) is (are) the person(s) so named by the Insured for the Policy as shown on the Policyholder’s records kept on the Policy. The Insured Dependent’s beneficiary is the Insured.

A legally competent Insured over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company, Administrator, or broker or, if agreed upon in advance by the Company, the Policyholder with a written request for change. When the request is received by the Company, Administrator, or broker or, if agreed upon in advance by the Company, the Policyholder, whether the Insured Person is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment which is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living on the date of the Insured’s death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Insured’s (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured Person’s estate.

If no beneficiary for an Insured Dependent’s coverage is living on the date of the Insured Dependent’s death, the beneficiary is the Insured’s estate.
Honoring Beneficiary Information from a Prior Plan. The Insured’s beneficiary should be named on a form acceptable to the Company. If not, the Company may make all payments to the last person named by the Insured as a beneficiary under a policy that ended before becoming insured under the Policy.

The Company may use information from the prior carrier’s records to determine any payment made such as:

1. information about the last beneficiary named by the Insured under the Policy, or any other group policy; or
2. information that the Insured named no beneficiary under the Policy, or any other group Policy.

If information shows that no beneficiary was named, the Company may make all payment under the Beneficiary Designation and Change provision.

Physical Examination and Autopsy. The Company at its own expense shall have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy as often as it may reasonably require during the review of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. This provision is not applicable to group life insurance benefits.

Noncompliance with Policy Requirements. Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes. Any provision of the Policy which, as of its Policy Effective Date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

Workers’ Compensation. The Policy is not in lieu of and does not affect any requirements for coverage by any Workers’ Compensation Act or similar law.

Clerical Error. A purely clerical error, which arises from other than a failure to perform administrative duties hereunder, whether by the Policyholder or the Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect; nor will it extend insurance of such person if that insurance would otherwise have ended or been reduced as provided in the Policy. Clerical error may be, by illustration but not limitation, errors in transcription or computation, but is not, by illustration but not limitation, a failure to advise Insured Persons of procedural requirements.

Assignment. The Policy is non-assignable. An Insured may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.
Section VI  GENERAL PROVISIONS

Misstatement of Facts. If the material facts, including age, of the Insured Person were not accurate in the application to the Policy:

1. a fair adjustment of premium based on the applicable rates for the true age of the Insured Person will be made; and

2. the true facts, including true age, will decide whether and in what amount of insurance is in force under the Policy.

After an Insured Person has been covered under the Policy for two years no statement made by the Insured Person will be used to contest a claim under the Policy. The Company can only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the Insured Person’s beneficiary.

Facility of Payment. If an individual appears to the Company to be equitably entitled to compensation because he or she has incurred expenses on behalf of an Insured Person or for burial or funeral expenses, the Company may deduct from the amount payable under the Policy to be paid to such individual the expenses incurred, but not more than $2,000. Such payment will not exceed the amount due under the Policy.

Settlement Options. The Insured may elect to have all or any part of his or her Life Insurance Benefit Amount(s) paid to his or her beneficiary in installments or in any other way that may be agreed to by the Company. The Insured must give notice in writing to elect a settlement option. The Insured will have the right to change the election at any time. The terms of payment will be in accordance with those offered by the Company for the insurance at the time election is made.

After the Insured's death, the beneficiary:

1. may make such an election, if the Insured had not done so; and

2. may name a person(s) to receive any amount which would otherwise go to the beneficiary's estate; and

3. will have the right to change the person(s) named in accordance with 2. above.

Interest on Death Benefits Payable in a Lump Sum. Interest on Life Insurance Benefit Amount(s) paid in a lump sum for the loss of life of the Insured Person shall be paid to the Insured Person's beneficiary. Such interest shall be computed daily at the rate of interest currently payable by the Company on proceeds left under the interest settlement option, from the date of death of the Insured Person to the date of payment. Such amount shall be added to and be a part of the total Life Insurance Benefit Amount(s) paid for loss of life.

Agency. For the purposes of the Policy, the Policyholder acts on its own behalf or as the agent of the Insured Person. Under no circumstances will the Policyholder be deemed the agent of the Company without written authorization.
Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

<table>
<thead>
<tr>
<th>The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES, SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.</strong></td>
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<tr>
<td>The Missouri Life and Health Insurance Guaranty Association</td>
</tr>
<tr>
<td>994 Diamond Ridge, Suite 102</td>
</tr>
<tr>
<td>Jefferson City, MO  65109</td>
</tr>
<tr>
<td>Missouri Department of Insurance</td>
</tr>
<tr>
<td>P.O. Box 690</td>
</tr>
<tr>
<td>Jefferson City, MO  65102-0690</td>
</tr>
</tbody>
</table>

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. Following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.
Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when --

1. The person is eligible for protection under the laws of another state;

2. The person purchased the insurance from a company that was not authorized to do business in this state;

3. The policy is issued by an organization which is not a member insurer of the association; or

4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers’ plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees).

The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars ($100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars ($100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars ($100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($300,000) for any one insured for any combination of insurance benefits.
The following section applies only to those persons who are eligible for and have enrolled in the Group Term Life and AD&D Plan.
If you have any questions regarding your group insurance plan, please send your correspondence to:

AIG Benefit Solutions
PO Box 30066
Tampa, FL 33630-3066

Policy issued by:

American General Life Insurance Company
Houston, Texas

The United States Life Insurance Company in the City of New York
New York, New York

New York, New York

AIG Benefit Solutions® is the marketing name for the domestic benefits division of American International Group, Inc.

The underwriting risks, financial and contractual obligations, and support functions associated with products issued by American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, Pa. are the issuing insurer’s responsibility. The United States Life Insurance Company in the City of New York and National Union Fire Insurance Company of Pittsburgh, Pa. are authorized to conduct insurance business in New York. Policies are not available in all states.
CERTIFICATE OF INSURANCE

American General Life Insurance Company (the Company) certifies that certain eligible persons are insured for the benefits described in this certificate. This insurance is subject to the eligibility and effective date requirements described in the ELIGIBILITY section of this certificate.

IMPORTANT NOTICE

This certificate is a summary of the group policy provisions that affect your insurance. It is merely evidence of the insurance provided by such policy for SAINT LOUIS UNIVERSITY (the Policyholder).

The group policy is a contract between the Company and the Policyholder. It may be changed or ended without notice to or consent of any insured person.

This certificate replaces any certificate previously issued by the Company to you under the group policy.

The benefits described in this certificate are provided by group policy no. 40G620.

The Company is providing this electronic version of the certificate at the request of the Policyholder. The Policyholder maintains the group policy, which includes a copy of the certificate. The group policy is available for you to review and copy. If there is any conflict between the information in this electronic version of the certificate and the group policy, the group policy will control in all respects.

PLEASE READ THIS CERTIFICATE CAREFULLY
# CERTIFICATE INDEX

<table>
<thead>
<tr>
<th>Section I Definitions</th>
<th>Page</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Section II Eligibility</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Classes</td>
<td>9</td>
</tr>
<tr>
<td>Eligibility</td>
<td>9</td>
</tr>
<tr>
<td>Insured's Effective Date</td>
<td>9</td>
</tr>
<tr>
<td>Late Entrants</td>
<td>9</td>
</tr>
<tr>
<td>Change in Family Status</td>
<td>9</td>
</tr>
<tr>
<td>Evidence of Insurability Requirement</td>
<td>10</td>
</tr>
<tr>
<td>Actively At Work Requirement</td>
<td>10</td>
</tr>
<tr>
<td>Dependent Eligibility</td>
<td>10</td>
</tr>
<tr>
<td>Insured Dependent's Effective Date</td>
<td>10</td>
</tr>
<tr>
<td>Effective Date of Changes</td>
<td>11</td>
</tr>
<tr>
<td>No Loss/No Gain</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section III Date Insurance Ends</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured's Termination Date</td>
<td>12</td>
</tr>
<tr>
<td>Insured Dependent's Termination Date</td>
<td>12</td>
</tr>
<tr>
<td>Reinstatement of Insurance</td>
<td>12</td>
</tr>
<tr>
<td>Exceptions to Termination of Insurance</td>
<td>13</td>
</tr>
<tr>
<td>Suspension of Coverage During Military Service</td>
<td>13</td>
</tr>
<tr>
<td>Continuation of Coverage While on Leave under the Family and Medical Leave Act</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section IV Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td></td>
</tr>
<tr>
<td>Death Benefit</td>
<td>14</td>
</tr>
<tr>
<td>Reduction Schedule</td>
<td>14</td>
</tr>
<tr>
<td>Extension of Life Insurance</td>
<td>14</td>
</tr>
<tr>
<td>Waiver of Premium Benefit</td>
<td>14</td>
</tr>
<tr>
<td>Conversion Privilege</td>
<td>15</td>
</tr>
<tr>
<td>Portability</td>
<td>16</td>
</tr>
<tr>
<td>Accelerated Life Insurance Benefit</td>
<td>17</td>
</tr>
<tr>
<td>Limitations</td>
<td>18</td>
</tr>
<tr>
<td>Dependent Life Insurance</td>
<td>18</td>
</tr>
<tr>
<td>Conversion Privilege</td>
<td>18</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Insurance</td>
<td></td>
</tr>
<tr>
<td>Accidental Death Benefit</td>
<td>20</td>
</tr>
<tr>
<td>Accidental Dismemberment Benefit</td>
<td>20</td>
</tr>
<tr>
<td>Day Care Benefit</td>
<td>20</td>
</tr>
<tr>
<td>Exposure and Disappearance</td>
<td>21</td>
</tr>
<tr>
<td>Limitation on Multiple Benefits</td>
<td>21</td>
</tr>
<tr>
<td>Repatriation of Remains Benefit</td>
<td>21</td>
</tr>
<tr>
<td>Seat Belt and Air Bag Benefit</td>
<td>22</td>
</tr>
<tr>
<td>Tuition Benefit</td>
<td>22</td>
</tr>
<tr>
<td>Permanent Total Disability Benefit</td>
<td>23</td>
</tr>
<tr>
<td>Exclusions</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section V Claims Provisions</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Section VI General Provisions</th>
<th></th>
</tr>
</thead>
</table>
SCHEDULE OF BENEFITS

Eligible Class(es):

Class 2 - All active full-time employees of the Hotel Ignacio who are citizens or legal residents of the United States

FULL-TIME means active work on the Policyholder’s regular work schedule for the class of employees to which you belong. The work schedule must be at least 32 hours a week.

Policy Effective Date: January 1, 2014

Policy Anniversary Date: January 1, 2015, and each subsequent January 1

Waiting Period:

Present Eligible Persons...........................................The first day of the month following the date he or she enters an eligible class
Future Eligible Persons..................................................The first day of the month following the date he or she enters an eligible class

LIFE INSURANCE

Basic Life Insurance

Basic Life Insurance Benefit Amount........................................... An amount equal to the Insured's Basic Earnings, rounded to the next higher $1,000 multiple, if not one already, with a minimum of $10,000

Basic Life Insurance Maximum.................................................................$400,000
Basic Guaranteed Issue Amount.................................................................$400,000

Supplemental Life Insurance

Supplemental Life Insurance Benefit Amount..................... An amount equal to one, two or three times the Employee's Basic Earnings, rounded to the next higher $1,000 multiple, if not one already, which when combined with the BASIC amount does not exceed $400,000

Supplemental Life Insurance Maximum ..........................................................$400,000
Supplemental Life Insurance Guaranteed Issue Amount ........ The lesser of: $400,000, or an amount equal to the three times the Employee's Basic Earnings

Supplemental Dependent Life Insurance

Supplemental Life Insurance Benefit Amount

Insured Spouse.................................................................................................$25,000
Spouse Maximum Amount ..................................................................................$25,000
Spouse Guaranteed Issue Amount .......................................................................$25,000

Insured Dependent Children

Birth to 19 years.................................................................................................$12,500

Full-time student

19 years to 23 years..........................................................................................$12,500
Child Guaranteed Issue Amount..........................................................................$12,500
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) Benefit

AD&D Principal Sum............................................................ An amount equal to the Insured's Basic Earnings, rounded to the next higher $1,000 multiple, if not one already, with a minimum of $10,000

AD&D Insurance Maximum........................................................................................................ ..$600,000

Basic Life Insurance Reduction Schedule

50% of the scheduled amount at age 70

Supplemental Life Insurance Reduction Schedule

50% of the scheduled amount at age 70

AD&D Insurance Reduction Schedule

65% of the scheduled amount at age 70
45% of the scheduled amount at age 75
30% of the scheduled amount at age 80
20% of the scheduled amount at age 85
Section I  DEFINITIONS

ACCIDENT means an unexpected and undesirable event or occurrence that is sudden, unforeseen and unintended.

ACTIVE WORK/ACTIVELY AT WORK means performing normal duties for the Policyholder at the usual place of employment, an alternative work site at the direction of the Policyholder, or at a location to which the Policyholder requires the Insured to travel. An Insured will be considered Actively At Work on each regularly scheduled non-work day if he or she was Actively At Work on the immediately preceding scheduled work day, provided the Insured is not Totally Disabled.

ACTIVITIES OF DAILY LIVING (ADL) means the following activities:

- Bathing - the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;
- Dressing - the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting - the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- Transferring - the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment;
- Mobility - the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and
- Continence - the ability to voluntarily maintain control of bowel and/or bladder function or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

AUTOMOBILE means a self-propelled private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, or jeep-type vehicle and, if not used primarily for occupational, professional or business purposes, a motor vehicle of the pickup, panel, van, camper or motor home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

BASIC EARNINGS means the Insured’s annual compensation from the Policyholder.

Basic earnings includes:

- the Insured's average monthly compensation from the Policyholder during the Policyholder’s prior tax year if the Insured was a Partner, Professional Corporation (P.C.) Partner, Owner-employee, Sole Proprietor and/or S-Corporation Shareholder;
- the average annual compensation received by the Insured’s professional corporation from the Policyholder during the Policyholder’s prior tax year. The Company will calculate annual earnings by adding the following items as reported on the applicable Schedule K-1, Schedule C, Form W-2, or S-Corporation federal income tax return, or by the number of months that the Insured was a Partner, Professional Corporation (P.C.) Partner, Owner-employee, Sole Proprietor and/or S-Corporation Shareholder if less than 12 months. This includes the Insured’s:
  - ordinary income from trade or business activities;
  - guaranteed payments if he or she was a Partner;
  - net profit from the business;
  - compensation (as an officer), salary or wages, if he or she was a S-Corporation Shareholder
Section I  DEFINITIONS

- the Insured’s average annual rate of compensation from the Policyholder including:
  - average annual salary
  - regular hourly wages (but not for more than 40 hours a week)
  - commissions averaged over the preceding 24 months or the period of the Insured’s employment if less than 24 months
- shift differential pay
- contributions the Insured makes through a salary reduction agreement with the Policyholder to:
  - an Internal Revenue Code (IRC) 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement;
  - an executive nonqualified deferral compensation arrangement
- amounts contributed to the Insured’s fringe benefits according to a salary reduction agreement under an IRC section 125 plan.

Basic earnings does not include:

- bonuses
- overtime pay
- extra compensation
- the Policyholder’s contributions on the Insured’s behalf to any deferred compensation plan or pension plan
- income the Insured earns as a private contractor on IRS form 1099
- stock options

CHANGE IN FAMILY STATUS means:

- an Insured’s marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
- the death of or divorce from an Insured’s spouse;
- the death of or emancipation of a child;
- Spouse’s loss of employment which results in a loss of group insurance; or
- change in classification from part-time to full-time or from full-time to part-time.

COGNITIVE IMPAIRMENT means that the Insured has been certified by a Physician as having a deterioration or loss in intellectual capacity, resulting from Injury, Sickness, Alzheimer’s disease or similar forms of irreversible dementia, and the Insured needs another person’s active help or verbal guidance for his or her own protection and the protection of others.

DAY CARE CENTER means a facility that is duly licensed, certified or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction.
DEFINITIONS

DEPENDENT CHILD(REN) means the Insured’s unmarried children, including natural, step, foster or adopted children from the moment of placement in the home of the Insured, under age 19, (19 - 23 if attending an accredited Institution of Higher Learning on a full time basis) and primarily dependent on the Insured for support and maintenance.

Any unmarried Dependent Children of the Insured covered under the Policy before reaching the age limit specified above, who are incapable of self-sustaining employment by reason of mental or physical incapacity, and who are primarily dependent on the Insured for support and maintenance, may continue to be eligible under the Policy beyond that age limit for as long as the Policy is in force, but only if they remain continuously covered under the Policy. The Company may request that the Insured submit satisfactory proof of the Dependent Child(ren)'s incapacity and dependency to the Company within 60 days before the Dependent Child(ren) reach the age limit specified above. If the Insured fails to furnish the requested proof before the Dependent Child(ren) reach the age limit, coverage for the Eligible Dependent Child(ren) will not be extended past the age limit. If coverage is extended, the Company may request that the Insured submit satisfactory proof of the Dependent Child(ren)'s continued incapacity and dependency to the Company on an annual basis.

If the Insured fails to furnish the requested proof within 31 days of the request, coverage for the Dependent Child(ren) will terminate at the end of that 31-day period.

EVIDENCE OF INSURABILITY means a statement or proof of a person’s medical history upon which acceptance for insurance will be determined by the Company.

FAMILY COVERAGE means coverage in force under the Policy on an Insured’s Eligible Dependents: (1) whom the Insured has elected to cover under the Policy; and (2) for whom premium has been paid.

GUARANTEED ISSUE AMOUNT means the amount of insurance that will be issued to an Insured Person without Evidence of Insurability. The Guaranteed Issue Amount for an Insured Person’s Life Insurance is shown in the Schedule. For amounts in excess of the Guaranteed Issue Amount, Evidence of Insurability satisfactory to the Company may be provided at the Insured’s expense.

IMMEDIATE FAMILY MEMBER means a person who is related to the Insured in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), grandparent, brother or sister (includes stepbrother or stepsister), child (includes legally adopted, stepchild, or foster child), aunt, uncle, niece, nephew, or grandchild.

INJURY means bodily injury that is the direct result of an Accident occurring while the Policy is in force with respect to the person whose injury is the basis of claim and resulting directly and independently of all other causes in a covered loss.

INSTITUTION OF HIGHER LEARNING means any accredited institution that provides education or training beyond the 12th grade level, including, but not limited to, any state university, private college, or trade school.

INSURED means a person who is a member of an Eligible Class for whom premium has been paid while covered under the Policy.

INSURED DEPENDENT means an Insured Dependent Child or an Insured Spouse, for whom premium is paid while covered under the Policy.

INSURED DEPENDENT CHILD means the Insured’s Dependent Child, for whom premium is paid while covered under the Policy.

INSURED PERSON means the Insured or an Insured Dependent.
Section I DEFINITIONS

INSURED SPOUSE means the Insured's Spouse, for whom premium is paid while covered under this Policy.

LOSS OF A HAND OR FOOT means complete severance through or above the wrist or ankle joint.

LOSS OF SIGHT OF AN EYE means total and irrecoverable loss of the entire sight in that eye.

MILITARY means the armed land, sea or air force of a nation.

PARAMILITARY means an organized, armed force on a Military pattern.

PERMANENTLY TOTALLY DISABLED/PERMANENT TOTAL DISABILITY means that the Insured is permanently unable to perform the material and substantial duties of the Insured's regular occupation for the initial benefit period of 12 months and following that period any occupation for which he or she is qualified by reason of education, experience or training.

PHYSICIAN means a licensed practitioner of the healing arts acting within the scope of his or her license, who is not: (a) the Insured Person; (b) an Immediate Family Member; (c) residing with the Insured Person; or (d) retained by the Policyholder.

PRIOR PLAN means the Group Life Insurance and Accidental Death and Dismemberment Insurance carried by the Policyholder on the day before the Policy Effective Date.

SCHEDULE means the Schedule of Benefits section of the Policy.

SICKNESS means illness or disease diagnosed by a Physician.

SPOUSE means the Insured’s lawful spouse (not including a spouse who is legally separated from the Insured).

SUPPLEMENTAL RESTRAINT SYSTEM means an air bag which inflates for added protection to the head and chest areas.

TOTAL DISABILITY/TOTALLY DISABLED means that, as a result of Injury or Sickness, the Insured is unable to perform the material and substantial duties of the Insured's regular occupation for the initial benefit period of 12 months and following that period any occupation for which he or she is reasonably qualified by education, training or experience.

WAR OR INSURRECTION means an armed conflict between the Military or Paramilitary forces of two (2) or more political entities.
Section II ELIGIBILITY

Eligible Classes

All active full-time employees of the Hotel Ignacio who are citizens or legal residents of the United States, but not those who are temporary, part-time or seasonal.

Eligibility. Before becoming eligible for coverage under the Policy, a Waiting Period must be satisfied by each member of an Eligible Class as shown in the Schedule.

Insured's Effective Date. An Insured's coverage under the Policy will become effective on the latest of the following dates:

If Non-Contributory

1. the Policy Effective Date; or
2. the first day of the month following the date the person becomes eligible for insurance;

If Contributory

1. the first day of the month following the date the person applies for insurance, if such date is within 31 days of his or her eligibility date;
2. the first day of the month following the date the Company approves the application for insurance and any required Evidence of Insurability, if application is made more than 31 days after his or her eligibility date;
3. the date for which the first premium for the person's coverage is paid; or
4. the Policy Effective Date.

Late Entrants

The following limitations will apply to a later enrollment: If the person does not enroll within 31 days after becoming eligible, he or she may only apply for coverage within 31 days of a Change in Family Status. The date that the person is insured will be the first day of the month following the date the Company approves application for insurance and any required Evidence of Insurability.

Change in Family Status

A Change in Family Status means:

1. An Insured's marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
2. The death of or divorce from an Insured's spouse;
3. The death of or emancipation of a child;
4. Spouse's loss of employment which results in a loss of group insurance; or
5. Change in classification from part-time to full-time or from full-time to part-time.

The Insured will be allowed to enroll or increase one increment if a Change in Family Status applies.
Evidence of Insurability Requirement

Evidence of insurability is required if the person:

- is a late applicant, which means that he or she requests insurance more than 31 days after the date he or she is eligible;
- voluntarily canceled his or her insurance and is reapplying;
- applies after any of his or her coverage ended because he or she did not pay a required contribution, or
- has not met a previous Evidence of Insurability requirement to become insured under any plan the Policyholder has with the Company.

Any Life Insurance which is in excess of the Guaranteed Issue Amount or is subject to Evidence of Insurability shall become effective on the date the Company approves evidence that the person is insurable, subject to any applicable waiting period.

Actively At Work Requirement

If the person is not Actively at Work on the date his or her insurance would otherwise become effective, insurance will not be effective until the date such person returns to and remains Actively at Work.

Dependent Eligibility. An Insured’s Dependents are eligible for Dependent Life Insurance benefits under the Policy on the day the Insured becomes eligible for dependent coverage. However a Dependent can only be either an Insured or a Dependent under the same policy, not both.

Insured Dependent’s Effective Date. An Insured Dependent’s coverage under the Policy will become effective on the latest of the following dates:

1. the Policy Effective Date;
2. the Insured’s effective date of insurance;
3. the date for which the first premium for the person’s coverage is paid;
4. the date the Insured elects dependent coverage under the Policy; or
5. the date the Company approves the application for insurance and any required Evidence of Insurability, if application is made more than 31 days after the dependent’s eligibility date.

Any Life Insurance which is in excess of the Guaranteed Issue Amount or is subject to Evidence of Insurability shall become effective on the date the Company approves evidence that the person is insurable, subject to any applicable waiting period.

If the person is unable to engage in the normal activities of a person in good health of like age and sex on the date the insurance would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex.
Section II ELIGIBILITY

Effective Date of Changes. Any change in the amount of an Insured’s insurance due to a change in Basic Earnings will take effect on the Policy Anniversary Date immediately following the date of such change. Any change in the amount of an Insured’s insurance due to his or her becoming a member of another Eligible Class will take effect on the Policy Anniversary Date immediately following the date of such change.

If the Insured is not Actively at Work on the date that an increase in his or her coverage is to take effect, such increase will be effective on the date the Insured returns to Active Work.

If an Insured Dependent is unable to engage in the activities of a person in good health of like age and sex on the date an increase in his or her Dependent Life Insurance Benefit Amount would otherwise become effective, such increase will not be effective until the date such Insured Dependent is able to engage in normal activities of a person in good health of like age and sex.

No Loss / No Gain

If a person is absent from work due to a physical or mental condition on the date his or her insurance would otherwise have become effective, the effective date of the person’s insurance will be deferred until the date he or she returns to Active Work.

If the person was insured under the Prior Plan on the day before the Policy Effective Date and would be eligible for coverage on the Policy Effective Date; except that he or she is not able to meet the requirements of Actively at Work; then the coverage amount shown in the Schedule of Insurance will not apply to such person.

Instead, the person will be considered to be insured and the Company’s coverage amount will be the lesser of:

1. the amount of Life Insurance and Accidental Death and Dismemberment Insurance under the Prior Plan; or
2. the amount of Life Insurance and Accidental Death and Dismemberment Insurance shown in the Schedule of Insurance, reduced by any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan.

The person will remain insured under this provision until the first to occur of:

1. the date he or she returns to Active Work;
2. the date his or her insurance terminates for a reason stated under the termination provision;
3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or
4. the last day the person would have been covered under the Prior Plan, had the Prior Plan not terminated.
Section III \hspace{1cm} DATE INSURANCE ENDS

Insured’s Termination Date. An Insured’s coverage under the Policy will end on the earliest of the following dates:

1. the premium due date, if premiums are not paid when due (subject to the grace period);
2. at the end of the month following the date the Insured ceases to be a member of an Eligible Class;
3. the date the Policy terminates; or
4. the date the Insured notifies the Company in writing to discontinue his or her coverage.

With respect to Accidental Death and Dismemberment Insurance, termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from an accident that occurred while the Insured’s coverage was in force under the Policy.

Insured Dependent’s Termination Date. An Insured Dependent’s coverage under the Policy ends on the earliest of the following dates:

1. at the end of the month following the date the Insured’s coverage under the Policy ends;
2. at the end of the month following the date the person ceases to qualify as an Insured Dependent;
3. the premium due date, if premiums are not paid when due (subject to the grace period);
4. at the end of the month following the date the Insured is no longer eligible for dependent coverage;
5. the date dependent coverage is no longer provided by the Policy;
6. the date the Insured notifies the Company in writing to discontinue his or her dependent coverage;
7. the date the coverage terminates; or
8. the date the Policy terminates.

Reinstatement of Insurance. If insurance ends because the Insured ceases to be eligible for coverage as defined in this Certificate, coverage may be reinstated and no additional waiting period will apply if, within six months after the date the insurance ends, the Insured becomes a member of an Eligible Class. If insurance ends because of default in payment on the part of the Insured, coverage may be reinstated at any time within 5 years after date of default upon presentation of evidence of insurability satisfactory to the Company and payment of all premiums in arrears.
Exceptions to Termination of Insurance. If the Insured terminates Active Work and if premium payments for his or her coverage are made when due, he or she may be considered to be Actively at Work, subject to the conditions set forth below.

1. If the Insured terminates Active Work due to temporary lay off or leave of absence, coverage may be continued until the earliest of the following dates:
   a. the date the Policyholder ceases to pay the Insured's premiums, or otherwise terminates the insurance; or
   b. 31 days from the date the Insured ceases to be Actively at Work; or
   c. the date the Policy terminates.

2. If the Insured terminates Active Work due to Injury or Sickness, coverage under the Policy may be continued in accordance with the Extension of Life Insurance provision. However, if the insured is not eligible for continuance under the Extension of Life Insurance Provision and is no longer Actively at Work due to injury or Sickness, then the longest they can be covered is for 12 months unless age 65 or older.

Suspension of Coverage During Military Service

The Company will suspend the Insured's insurance on the date he or she goes on active duty in the Military service of any country or international authority. Such duty will not include temporary active duty by reservists for military training that lasts 90 days or less. The Company will refund that part of any premium paid for the period of such suspension.

A person can place his or her insurance back in force without Evidence of Insurability or earned income as of the date of his or her discharge. To do so, he or she must apply in writing and pay the premium, both within 90 days after active duty ends.

The Company will base the person's premium on his or her age and class of risk when such person's insurance was suspended. If the person was disabled on or before the date of discharge, he or she must have recovered for at least 6 months before the Company will cover a later disability from the same cause.

Continuation of Coverage While on Leave under the Family and Medical Leave Act

If an Insured is eligible for and the Policyholder approves a leave of absence under the Federal Family and Medical Leave Act of 1993 (FMLA) or any similar state law, his or her insurance will continue for a period of up to 12 weeks following the date the leave begins provided the Policyholder pays the required premiums in accordance with the provisions of the group policy. The Company may require written confirmation of the FMLA approval from the Policyholder.

The Insured is eligible for leave under this act in order to provide care:

- after the birth of a child
- after the legal adoption of a child
- after the placement of a foster child in his or her home
- to a spouse, child or parent due to their serious illness, or
- for the Insured's own serious health condition.

If the Insured does not continue his or her insurance during the FMLA leave, upon his or her return to active employment:

- no new waiting period will be applied
- no new pre-existing conditions exclusions or limitations will be applied, and
- no Evidence of Insurability will be required to reinstate the insurance in effect before the leave began.
LIFE INSURANCE

Death Benefit. Upon receipt of due proof of death, the Company will pay the Life Insurance Benefit Amount(s) in force on the Insured’s life at the time of his or her death, in accordance with the terms of the Policy. In no event will the total amount of Life Insurance in force for an Insured exceed the Life Insurance Maximum shown in the Schedule.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.

Reduction Schedule. The Basic and Supplemental Life Insurance Benefit Amount(s) payable with respect to an Insured Person will be reduced to the Percentage of Scheduled Benefit when the Insured Person attains the ages shown in the Schedule. The Accidental Death and Dismemberment Insurance benefits payable with respect to an Insured Person will be reduced to the Percentage of Scheduled Benefit if the Insured Person has attained the ages shown in the Schedule on the date of the accident causing the loss.

These reductions will also apply to any insurance that is extended in accordance with the Extension of Life Insurance provision in this Policy. Any decrease in the amount of insurance due to age will take place on the Insured Person’s birthday.

"Age" as used above refers to the age of the Insured Person on his or her most recent birthday, regardless of the actual time of birth.

"Scheduled Benefit" as used above refers to the applicable benefit amount shown in the Schedule that would otherwise be payable in the absence of any benefit reduction.

Extension of Life Insurance

Waiver of Premium Benefit. If the Insured becomes Totally Disabled before reaching age 60, his or her Basic and Supplemental Life Insurance under this Policy will continue for one year from the date the Insured becomes Totally Disabled, provided that the Insured remains Totally Disabled, and premiums are paid when due. The Life Insurance benefit will be the same amount for which the Insured would have been eligible if he or she were not Totally Disabled, subject to any applicable benefit reduction. Insurance may be continued beyond such one-year period, provided:

1. the Insured furnishes proof satisfactory to the Company, at least 180 days from the date such Total Disability began, that the Insured has been Totally Disabled continuously from the date the Total Disability began; and

2. such proof is furnished to the Company no later than one year after the date the Total Disability begins.

Upon submission of the required proof, premiums paid on the Insured’s behalf during the Total Disability will be refunded. The Company will waive the required premium payments until the Insured is no longer Totally Disabled, provided the Insured: (a) furnishes proof that the Total Disability has continued uninterrupted; and (b) submits to a physical exam when required, as provided below.
Section IV  
BENEFITS

Benefits will end on the earliest of the following dates:

1. the date the Insured ceases to be Totally Disabled;
2. the date the Insured fails to submit to a physical exam as required;
3. the date the Insured’s Life Insurance would otherwise terminate as indicated in the Policy;
4. the date proof of Total Disability is not provided when due; or
5. the date the Insured reaches age 70.

If the Insured ceases to be Totally Disabled, premiums must be paid when due if insurance coverage is to be continued.

Physical Exam. The Company will have the right to have a Physician of its choice examine the Insured to establish any disability. The Company will pay for the exam. The Insured may be examined as often as reasonably necessary during the period of disability, but not more than once a year after he or she has been disabled for two years.

Conversion After Extension. When any applicable extension of benefits described in this section ends, the Insured may convert his or her coverage to an individual insurance policy, provided the Insured is Entitled to Convert as described in the Conversion Privilege provision.

Conversion Privilege

The Insured may convert his or her Life Insurance under the Policy to an individual policy if such insurance, or any portion of it, ends, provided the Insured is Entitled to Convert and, within 31 days after such insurance ends the Insured:

1. applies in writing to the Company at P.O. Box 30066, Tampa, Florida 33630-3066; and
2. pays the first premium.

Evidence of Insurability. No Evidence of Insurability will be required if the Insured converts to an individual policy under this Conversion Privilege.

Entitled to Convert. The Insured is Entitled to Convert his or her Life Insurance only if:

1. the Insured ceases to be a member of an Eligible Class as described in the Eligible Class(es) section of the Schedule;
2. the Policy terminates, provided the Insured has been covered under the Policy for at least five consecutive years immediately preceding such termination;
3. the Policy is amended to terminate the Eligible Class to which the Insured belongs, provided he or she has been covered under the Policy for at least five consecutive years immediately preceding such termination;
4. the employment of the Insured terminates.

In no event will the Insured be Entitled to Convert if his or her coverage under the Policy ceases due to non-payment of the required premium.
Section IV  BENEFITS

**Amount of Converted Life Insurance.** If the Insured’s coverage terminates because he or she is no longer a member of an Eligible Class, the amount of Life Insurance that he or she will be eligible to convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Insured’s Life Insurance ends because the Policy is amended to terminate the Eligible Class to which he or she belongs, or if the Policy terminates or the employment of the Insured terminates, the amount of Life Insurance under the converted life policy will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time insurance ends, less any amount for which the Insured becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000.

**Type of Policy.** The individual policy will be the Company’s current offering and will be on a form customarily issued by the Company. However, such policy may not be term insurance. No disability or other supplemental benefits will be covered under the policy. The individual policy will go into effect at the end of the period during which the Insured is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the policy can be contested, such time periods will be deemed to have begun at the time the Insured was first covered under the Policy.

The premium will be based on the Company’s rates for the individual policy form, the benefit amount, age and the class of risk to which the Insured belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

**Death During the Conversion Period.** If the Insured dies within the 31-day conversion period, the Company will pay a death benefit equal to the maximum amount the Insured could have otherwise converted.

**Notice of Conversion Right.** Notice of the Insured’s right to convert to an individual policy will be presented to the Insured or delivered to the Insured’s last known address within 15 days from the date his or her coverage ends. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.

**Portability**

In lieu of the Conversion Privilege stated above, if the Insured ceases to be a member of an Eligible Class for any reason other than retirement, the Insured may elect to convert his/her Supplemental Life Insurance to another Group Policy offered by the Company or an affiliate of the Company provided he or she has not attained age 70. The Insured may also elect to continue Dependent Life Insurance on his or her Insured Dependent Spouse provided the Insured Dependent Spouse has not attained age 70. The Insured must: (a) make such election within 31 days of termination of eligibility, and (b) agree to pay the entire premium for such coverage.

This coverage will be subject to all of the provisions and limitations of the Portability Policy, including reductions for age or termination at age 70. Premium rates for coverage under the Portability Policy will be based on the Insured’s age, sex and smoking status at the time of election of this option and at renewal. Coverage provided under this provision will end when the Portability Policy terminates but will continue through the last period for which premiums have been paid. Premiums for this coverage will be billed directly to the Insured on a quarterly, semi-annual or annual basis, as elected by the Insured.

The Portability Policy will contain a right to convert the Insured’s coverage to an individual policy offered by American General Life Insurance Company or an affiliate of the Company.
Section IV  BENEFITS

Accelerated Life Insurance Benefit

If elected by the Insured, and subject to approval by the Company, a portion of the Insured’s Life Insurance benefit may be paid before his or her death. To qualify for this benefit, the Insured must have been diagnosed as being terminally ill while insured under this Policy or must meet the qualifying conditions stated below. The Insured must apply for Accelerated Life Insurance benefits in writing on a form acceptable to the Company.

Qualifying Conditions

To qualify for this benefit, the Insured must: 1) be unable to continuously perform one or more Activities of Daily Living (ADL), without stand by help; 2) have a Cognitive Impairment; or 3) have a terminal illness.

Any activity of daily living the Insured is not able to perform, without stand by help, prior to the effective date of coverage will not be considered for qualifying for this benefit. Any Cognitive Impairments due to, caused by, or contributed by a cognitive condition that began prior to the effective date of coverage will not be considered for qualifying for this benefit.

Proof of Terminal Illness. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Company that the Insured’s life expectancy is 6 months or less from the date of application for this benefit. Proof of terminal illness must include certification from a Physician. The Company reserves the right to obtain a second or third medical opinion at its own expense.

Proof of other Qualifying Conditions. Before payment of benefits under this provision may be made, satisfactory proof must be provided to the Company that the person meets the qualifying conditions. Proof must be certified by a Physician and in the form that is satisfactory to the Company. The Company reserves the right to obtain a second or third medical opinion at its own expense.

Benefit Amount

The maximum benefit the Insured may receive under this provision is the lesser of:

1. 75% of the Insured’s Life Insurance benefit shown in the Schedule, including any Supplemental Life Insurance benefit less the amount of any benefit already paid under this provision; or

2. $250,000.

However if the Insured’s Life Insurance is scheduled to reduce within 6 months of the date application for this benefit is received by the Company, the Accelerated Life Insurance Benefit will be limited to the amount that would be available for accelerated payment after such reduction takes place.

The minimum Accelerated Life Insurance benefit the Insured may receive will be $1,000. Such benefit will be paid in a lump sum to the Insured, unless an alternate payment arrangement is requested by the Insured in writing and is approved by the Company. However, the minimum payment under such installment payment arrangement will be $500 per payment.

The receipt of this Accelerated Life Insurance benefit may be taxable. The Insured should seek assistance from a personal tax advisor with respect to receipt of this benefit. No representations as to any issue of taxation of this benefit are made by the Company.

Effect on Life Insurance Benefits at Insured’s Death. The Insured’s Life Insurance Benefit Amount(s) shown in the Schedule will be reduced by any amount paid under this provision.
Section IV BENEFITS

Termination of Accelerated Life Insurance Benefits. This benefit will terminate on the date the Insured’s insurance under the Policy terminates. However, this benefit will continue to be available while the Insured is covered under the Extension of Life Insurance provision of the Policy.

Limitations. The Company will not provide benefits under this provision if:

1. the Insured would be required by law to use the benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
2. the Insured is required by a government agency to use this benefit in lieu of applying for, obtaining, or otherwise keeping a government benefit or entitlement;
3. the Insured’s Life Insurance under the Policy has terminated;
4. each irrevocable beneficiary, if any, has disapproved payment of this benefit; or
5. the Insured’s Life Insurance benefits under the Policy have been assigned.
6. the Insured's terminal illness is the result of intentional self-inflicted injury or attempted suicide while sane.

Payees. Benefits will be paid in one lump sum to the insured, if living. If not living the Company may pay such benefits to the Insured's estate.

The Company will not be liable for such payment after it is made.

DEPENDENT LIFE INSURANCE

Death Benefit. Upon receipt of due proof of death, the Company will pay the Life Insurance Benefit Amount(s) in force on the Insured Dependent’s life at the time of his or her death, in accordance with the terms of the Policy. In no event will the total amount of Life Insurance in force for an Insured Dependent exceed the Life Insurance Maximum shown in the Schedule.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.

Conversion Privilege

An Insured Dependent may convert his or her Dependent Life Insurance under the Policy to an individual policy if such person's insurance, or any portion of it, ends, provided the individual is Entitled to Convert and, within 31 days after such insurance ends he or she:

1. applies in writing to the Company at P.O. Box 30066, Tampa, Florida 33630-3066; and
2. pays the first premium.

Evidence of Insurability. No Evidence of Insurability will be required for an Insured Dependent who converts to an individual policy under the Conversion Privilege.
Entitled to Convert. An Insured Dependent is Entitled to Convert his or her Life Insurance only if:

1. the Insured ceases to be a member of an Eligible Class as described in the Eligible Class(es) section of the Schedule;

2. the Insured dies;

3. the person ceases to qualify for coverage as an Insured Dependent, as defined in the Policy;

4. the Policy terminates, provided: (a) the Insured is Entitled to Convert; and (b) the Insured Dependent has been covered under the Policy for at least five consecutive years immediately preceding such termination;

5. the Policy is amended to terminate the Eligible Class to which the Insured belongs, provided: (a) the Insured is Entitled to Convert; and (b) the Insured Dependent has been covered under the Policy for at least five consecutive years immediately preceding such termination; or

6. the employment of the Insured terminates.

Amount of Converted Life Insurance. If the Insured Dependent ceases to be eligible for insurance under the Policy, the amount of Life Insurance he or she will be Entitled to Convert will not be more than the amount of Life Insurance that is lost under the Policy.

If the Insured Dependent’s Life Insurance ends because the Policy is amended to terminate the Eligible Class to which the Insured belongs or the employment of the Insured terminates, or if the Policy terminates, the amount of Life Insurance the Insured Dependent will be Entitled to Convert will be the lesser of: (a) the amount of Life Insurance in force under the Policy at the time his or her insurance ends, less any amount for which he or she becomes eligible under this or any other group life policy during the 31-day conversion period; or (b) $10,000.

Type of Policy. The individual Policy will be the Company’s current offering and will be on a form customarily issued by the Company. However, such Policy may not be term insurance. No disability or other supplemental benefits will be covered under the policy. The individual policy will go into effect at the end of the period during which the Insured Dependent is eligible to convert.

If the individual policy contains a provision which restricts the time within which benefits would be payable as a result of suicide, or restricts the time within which coverage under the policy can be contested, such time periods will be deemed to have begun at the time the Insured Dependent was first covered under the Policy.

The premium will be based on the Company’s rates for the individual policy form, the benefit amount, age and the class of risk to which the insured belongs at the time insurance ends. To continue insurance under the individual policy, the premium must continue to be paid as required under the terms of the individual policy.

Death During the Conversion Period. If the Insured Dependent dies within the 31-day conversion period, the Company will pay a death benefit equal to the maximum amount he or she could have otherwise converted.

Notice of Conversion Right. Notice of the Insured Dependent’s right to convert to an individual policy will be presented to him or her or delivered to the individual’s last known address within 15 days. If notice is not given within this 15-day period, the 31-day conversion period will be extended by 15 days after the date notice is given. However, in no event will the conversion period be extended for more than 60 days after the expiration date of the initial 31-day conversion period.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS AND COVERAGE

Principal Sum. As applicable to each Insured, Principal Sum means the amount(s) of insurance in force under this Policy on the date of the accident, as described in the Schedule. In no event will the total amount of Accidental Death and Dismemberment Insurance in force for an Insured exceed the AD&D Insurance Maximum shown in the Schedule.

As applicable to an Insured Dependent, Principal Sum means the amount of insurance in force under the Policy as described in the Schedule.

Accidental Death Benefit

If Injury to the Insured Person results in death within 365 days of the date of the Accident that caused the Injury, the Company will pay 100% of the Principal Sum.

Accidental Dismemberment Benefit

If Injury to the Insured Person results, within 365 days of the date of the Accident that caused the Injury, in any one of the Losses specified below, the Company will pay the percentage of the Principal Sum shown below for that Loss:

<table>
<thead>
<tr>
<th>For Loss of</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Hands or Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and the Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>50%</td>
</tr>
</tbody>
</table>

If more than one Loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

Day Care Benefit

If an Insured suffers accidental death such that an Accidental Death benefit is payable under the Policy on the date of the accident causing death, the Company will pay a benefit on behalf of any Dependent Child under age 13 who: (1) is enrolled in a Day Care Center on the date of the Insured's death; or (2) enrolls in a Day Care Center within 365 days after the Insured's death. The benefit is payable for each year of the Dependent Child's enrollment in a Day Care Center. The total amount of the benefit each year is equal to the least of:

1. the actual cost of care for that Dependent Child charged by that Day Care Center for that year;
2. 5% (in 1% increments to 10% and then 5% increments to the maximum) of the Insured's Principal Sum on the date of the accident causing death; or
3. $2,500 (in $1,000 increments to $10,000 and then $5,000 increments to the maximum).

The applicable portion of the yearly benefit for each period of enrollment is payable upon receipt of due proof of enrollment, but not more frequently than monthly.
Section IV  

BENEFITS

The benefit is not payable for any period of enrollment in a Day Care Center before the date of the accident that caused the Insured’s death. The benefit is not payable for any period of enrollment after the earlier of: (1) the date the Dependent Child reaches 13 years of age; or (2) the date four (4) years after the later of the date of the Insured’s death or the date the Dependent Child first enrolls in a Day Care Center.

Exposure and Disappearance

If by reason of an accident occurring while an Insured Person's coverage is in force under the Policy, the Insured Person is unavoidably exposed to the elements and as a result of such exposure suffers a loss for which a benefit is otherwise payable under the Policy, the loss will be covered under the terms of the Policy.

If the body of an Insured Person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provisions of the Policy, that the Insured Person has suffered accidental death within the meaning of the Policy.

Limitation on Multiple Benefits

If an Insured Person suffers one or more losses from the same accident for which amounts are payable under more than one of the following Benefits provided under the Policy, the maximum amount payable under all of the Benefits combined will not exceed the amount payable for one of those losses, the largest: Accidental Death Benefit, Accidental Dismemberment Benefit or Permanent Total Disability Benefit.

Repatiation of Remains Benefit

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, the Company will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $5,000 (in $5,000 increments to $100,000 and then in $25,000 increments to the maximum).

Covered expenses include, but are not limited to, expenses for: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

AIG Benefits Travel Assist℠ must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact AIG Benefits Travel Assist℠ in advance.

Exclusion 2 in the Exclusions section of the Accidental Death and Dismemberment Benefit provision in this Certificate does not apply with respect to this benefit.
Section IV  

BENEFITS

Seat Belt and Air Bag Benefit

Seat Belt Benefit. If the Insured Person suffers accidental death such that an Accidental Death benefit is payable under the Policy and the Accident causing death occurs while the Insured Person is operating, or riding as a passenger in, an Automobile and wearing a properly fastened, original, factory-installed seat belt or, if the person is a Dependent Child, a properly installed and fastened child restraint device as defined by state law, the Company will pay this additional benefit. The amount payable for this additional benefit is $10,000.

Air Bag Benefit. If a Seat Belt Benefit is payable and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the Company will pay an additional $10,000.

Verification of the actual use of the seat belt, at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

Tuition Benefit

If an Insured suffers accidental death such that an Accidental Death benefit is payable under the Policy on the date of the Accident causing death, the Company will pay the following benefit:

A. For the Dependent Children under Age 23. The Company will pay a benefit to or on behalf of any Dependent Child under age 23 who was insured under the Policy on the date of the Accident causing death and who, on the date of the Insured's death: (1) is a full-time student in any Institution of Higher Learning above grade 12; or (2) is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Insured's death. The benefit will be paid for each year of the Dependent Child's continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of four (4) consecutive years. The total amount of the benefit each year is equal to the least of:

1. the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Dependent Child;
2. 5% of the Insured's Principal Sum on the date of the Accident causing death; or
3. $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Insured’s death. If there is no Dependent Child under age 23 eligible for the benefit within 365 days after the date of the Insured’s death, the Company will pay a one-time lump sum benefit of 1000 to the Insured's designated beneficiary.
Section IV  BENEFITS

B. For the Insured Spouse. The Company will pay a benefit to or on behalf of any Spouse on the date of the Accident causing death and who, for the purpose of obtaining an independent source of support or to enrich his or her ability to earn a living: (1) is enrolled in any Institution of Higher Learning or professional or trade training program on the date of the Insured's death; or (2) subsequently enrolls in an Institution of Higher Learning or professional or trade training program within 30 months after the date of the Insured's death. The benefit will be paid for each year of the Spouse's continuous enrollment in an Institution of Higher Learning or professional or trade training program, to a maximum of four (4) consecutive years. The total amount of the benefit for all institutions and programs combined each year is equal to the least of:

1. the total actual tuition (exclusive of room and board) charged by those institutions or programs for enrollment during that year for the Spouse;

2. 5% of the Insured's Principal Sum on the date of the Accident causing death; or

3. $5,000.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment for that term.

A Spouse who ceases to be enrolled as described above becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment that begins before the date of the Insured’s death. If there is no Spouse eligible for the benefit within 30 months after the date of the Insured’s death, the Company will pay a one-time lump sum benefit of $1,000 to the Insured’s designated beneficiary.

Permanent Total Disability Benefit (Not Applicable to Insureds Age 70 or Older on the Date of the Accident)

If Injury renders an Insured Permanently Totally Disabled within 365 days of the Accident that caused the Injury, and if the Permanent Total Disability due to that Injury continues for a period of 12 consecutive months, the Company will pay a monthly benefit of 1% of the Principal Sum, starting with the 13th consecutive month of Permanent Total Disability. The benefit is payable monthly as long as the Insured remains continuously Permanently Totally Disabled due to that Injury, but ceases on the earliest of: (1) the date the Insured ceases to be Permanently Totally Disabled due to that Injury; (2) the date the Insured dies; or (3) the date the total amount of monthly Permanent Total Disability benefits paid for all Injuries caused by the same Accident equals 100% of the Principal Sum. The Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Company is liable when the Insured is Permanently Totally Disabled for less than a full month. Only one benefit is provided for any one month of Permanent Total Disability, regardless of the number of Injuries causing the Permanent Total Disability.

The Company reserves the right, at the end of the first 12 consecutive months of Permanent Total Disability (and as often as it may reasonably require thereafter) to determine, on the basis of all the facts and circumstances, that the Insured is Permanently Totally Disabled, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.
Section IV

BENEFITS

EXCLUSIONS

The Policy does not cover any loss caused in whole or in part by, or resulting in whole or in part from, the following:

1. suicide or any attempt at intentionally self-inflicted injury while sane (SEE STATEMENT BELOW);

2. sickness, disease or infections of any kind, except bacterial infections or pyogenic infections;

3. travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation on a regular schedule between established airports, if the Insured Person is:
   a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
   b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
   c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or by the Insured Person's employer;

4. declared or undeclared War, or any act of declared or undeclared War;

5. full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.);

6. the Insured Person being under the influence of drugs or under the influence of drugs or alcohol or voluntary intake of poison, drugs, gas, or fumes or intoxicants, unless taken under the advice of a Physician; or

7. the Insured Person's commission of or attempt to commit a crime.

SUICIDE - REQUIRED STATEMENT

Suicide is no defense to payment of life insurance benefits nor is suicide while insane a defense to payment of accidental death and dismemberment benefits, if any, under the Policy where the Policy is issued to a Missouri citizen, unless the Company can show that the Insured intended suicide when the Insured applied for the policy, regardless of any language to the contrary in the Policy.
Section V CLAIMS PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 20 days after an Insured Person’s loss, or as soon thereafter as reasonably possible. Notice given by or on behalf of the claimant to the Company at 3600 Route 66, Neptune, New Jersey, 07753, with information sufficient to identify the Insured Person, is deemed notice to the Company. This provision applies to accidental death and dismemberment coverage only.

Claim Forms. The Company will send claim forms to the claimant upon receipt of a written notice of claim. If such forms are not sent within 31 days after the giving of notice, the claimant will be deemed to have met the proof of loss requirements upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The notice should include the Insured Person's name, Policyholder’s name and the Policy number. This provision applies to accidental death and dismemberment coverage only.

Proof of Loss. Written proof of loss must be furnished to the Company within 90 days after the date of loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as the Company may reasonably require. Failure to furnish such proof within the time required, will not reduce or deny any benefits if the proof is given as soon as reasonably possible. However, in no event, other than legal incapacity, will proof be given more than one year after the date of loss. This provision applies to accidental death and dismemberment coverage only.

Payment of Claims. Upon receipt of due written proof of death, payment for loss of life of an Insured will be made to the Insured’s beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

Upon receipt of due written proof of loss, payments for all losses, except loss of life, will be made to (or on behalf of, if applicable) the Insured. If an Insured dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary as described in the Beneficiary Designation and Change provision of the General Provisions section.

If any benefit is payable to the estate of a person, or if any payee is a minor or otherwise not competent to give a valid release for the payment, the Company may make an initial payment, up to an amount not exceeding $2,000, to any relative by blood or connection by marriage of the payee who is deemed by the Company to be equitably entitled thereto. Such payment does not discharge the Company’s liability for any remaining benefits payable under the Policy.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

Time of Payment of Claims. Benefits payable under the Policy for any loss other than loss for which the Policy provides any periodic payment will be paid immediately upon the Company’s receipt of due written proof of the loss. Subject to the Company’s receipt of due written proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of such proof.
Entire Contract; Changes. The Policy, the Master Application, and any attached papers make up the entire contract between Policyholder and the Company. In the absence of fraud, all statements made by the Policyholder or any Insured Person will be considered representations and not warranties. No written statement made by an Insured will be used in any contest unless a copy of the statement is furnished to the Insured or his or her beneficiary or personal representative.

No change in the Policy will be valid until approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent may change the Policy or any of its provisions.

Incontestability. The validity of the Policy will not be contested after it has been in force for two years from the Policy Effective Date, except for non-payment of premium or fraudulent misrepresentation.

After an Insured Person has been covered under the Policy for two years no statement made by the Insured Person will be used to contest a claim under the Policy. The Company can only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the Insured Person's beneficiary.

Interpretation of the Policy. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

If this policy comprises a part of an employee benefits plan, the Company is granted the sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of this policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this policy or any other plan of benefits.

Beneficiary Designation and Change. The Insured’s designated beneficiary(ies) is (are) the person(s) so named by the Insured for the Policy as shown on the Policyholder's records kept on the Policy. The Insured Dependent's beneficiary is the Insured.

A legally competent Insured over the age of majority may change his or her beneficiary designation at any time, unless an irrevocable designation has been made. The change may be executed, without the consent of the designated beneficiary(ies), by providing the Company, Administrator, or broker or, if agreed upon in advance by the Company, the Policyholder with a written request for change. When the request is received by the Company, Administrator, or broker or, if agreed upon in advance by the Company, the Policyholder, whether the Insured Person is then living or not, the change of beneficiary will relate back to and take effect as of the date of execution of the written request, but without prejudice to the Company on account of any payment which is made prior to receipt of the request.

If there is no designated beneficiary, or if no designated beneficiary is living after the Insured's death, the benefits will be paid, in equal shares, to the survivors in the first surviving class of those that follow: The Insured’s (1) Spouse; (2) children; (3) parents; or (4) brothers and sisters. If no class has a survivor, the beneficiary is the Insured Person’s estate.

If no beneficiary for an Insured Dependent’s coverage is living on the date of the Insured Dependent’s death, the beneficiary is the Insured’s estate.
Section VI  GENERAL PROVISIONS

Honoring Beneficiary Information from a Prior Plan. The Insured’s beneficiary should be named on a form acceptable to the Company. If not, the Company may make all payments to the last person named by the Insured as a beneficiary under a policy that ended before becoming insured under the Policy.

The Company may use information from the prior carrier’s records to determine any payment made such as:

1. information about the last beneficiary named by the Insured under the Policy, or any other group policy; or

2. information that the Insured named no beneficiary under the Policy, or any other group Policy.

If information shows that no beneficiary was named, the Company may make all payment under the Beneficiary Designation and Change provision.

Physical Examination and Autopsy. The Company at its own expense shall have the right and opportunity to examine the person of any individual whose loss is the basis of claim under the Policy as often as it may reasonably require during the review of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished. This provision is not applicable to group life insurance benefits.

Noncompliance with Policy Requirements. Any express waiver by the Company of any requirements of the Policy will not constitute a continuing waiver of such requirements. Any failure by the Company to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes. Any provision of the Policy which, as of its Policy Effective Date, is in conflict with the statutes of the state in which the Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

Workers’ Compensation. The Policy is not in lieu of and does not affect any requirements for coverage by any Workers’ Compensation Act or similar law.

Clerical Error. A purely clerical error, which arises from other than a failure to perform administrative duties hereunder, whether by the Policyholder or the Company, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect; nor will it extend insurance of such person if that insurance would otherwise have ended or been reduced as provided in the Policy. Clerical error may be, by illustration but not limitation, errors in transcription or computation, but is not, by illustration but not limitation, a failure to advise Insured Persons of procedural requirements.

Assignment. The Policy is non-assignable. An Insured may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.
Section VI GENERAL PROVISIONS

Misstatement of Facts. If the material facts, including age, of the Insured Person were not accurate in the application to the Policy:

1. a fair adjustment of premium based on the applicable rates for the true age of the Insured Person will be made; and

2. the true facts, including true age, will decide whether and in what amount of insurance is in force under the Policy.

After an Insured Person has been covered under the Policy for two years no statement made by the Insured Person will be used to contest a claim under the Policy. The Company can only contest coverage if the misstatement is made in a written instrument signed by the Insured Person and a copy is given to the Policyholder, the Insured Person or the Insured Person's beneficiary.

Facility of Payment. If an individual appears to the Company to be equitably entitled to compensation because he or she has incurred expenses on behalf of an Insured Person or for burial or funeral expenses, the Company may deduct from the amount payable under the Policy to be paid to such individual the expenses incurred, but not more than $2,000. Such payment will not exceed the amount due under the Policy.

Settlement Options. The Insured may elect to have all or any part of his or her Life Insurance Benefit Amount(s) paid to his or her beneficiary in installments or in any other way that may be agreed to by the Company. The Insured must give notice in writing to elect a settlement option. The Insured will have the right to change the election at any time. The terms of payment will be in accordance with those offered by the Company for the insurance at the time election is made.

After the Insured's death, the beneficiary:

1. may make such an election, if the Insured had not done so; and

2. may name a person(s) to receive any amount which would otherwise go to the beneficiary's estate; and

3. will have the right to change the person(s) named in accordance with 2. above.

Interest on Death Benefits Payable in a Lump Sum. Interest on Life Insurance Benefit Amount(s) paid in a lump sum for the loss of life of the Insured Person shall be paid to the Insured Person's beneficiary. Such interest shall be computed daily at the rate of interest currently payable by the Company on proceeds left under the interest settlement option, from the date of death of the Insured Person to the date of payment. Such amount shall be added to and be a part of the total Life Insurance Benefit Amount(s) paid for loss of life.

Agency. For the purposes of the Policy, the Policyholder acts on its own behalf or as the agent of the Insured Person. Under no circumstances will the Policyholder be deemed the agent of the Company without written authorization.
Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES, SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.

The Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, MO 65109

Missouri Department of Insurance
P.O. Box 690
Jefferson City, MO 65102-0690

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. Following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.
Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when --

1. The person is eligible for protection under the laws of another state;

2. The person purchased the insurance from a company that was not authorized to do business in this state;

3. The policy is issued by an organization which is not a member insurer of the association; or

4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers’ plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees).

The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars ($100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars ($100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars ($100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($300,000) for any one insured for any combination of insurance benefits.
ADDENDUM TO SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by American General Life Insurance Company represents a portion of a Summary Plan Description required by the Employee Retirement Income Security Act of 1974 to be distributed to participants in the Plan.

PLAN NAME:

PLAN SPONSOR: SAINT LOUIS UNIVERSITY

SPONSOR’S EMPLOYER IDENTIFICATION NUMBER (EIN):

PLAN NUMBER:

TYPE OF PLAN: GROUP TERM LIFE AND AD&D

PLAN ADMINISTRATOR:

AGENT FOR SERVICE OF LEGAL PROCESS:

SOURCES OF CONTRIBUTIONS:

PLAN’S YEAR ENDS ON:

American General Life Insurance Company is granted sole discretionary authority, as Claims Administrator/Insurer, to determine eligibility, make all factual determinations and to construe all terms of the policy/plan. The Plan Sponsor may terminate the policy/plan, or, subject to American General Life Insurance Company’s approval, may modify, amend or change the provisions, terms and conditions of the plan. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured or any other person referred to in the policy/plan will be required to terminate, modify, amend or change the policy/plan. See your Plan Administrator to determine what, if any arrangements may be made to continue your coverage beyond the date you cease active work.

STATEMENT OF ERISA RIGHTS

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:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan Administrator with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan’s annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Claims Administrator/Insurer review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If the 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 the court costs and legal fees. If you are successful, the court may order the person you have sued to pay court costs and fees. If you lose, and the court finds your claim was frivolous, it may order you to pay these costs and fees.

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, 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.

Claims Filing Procedures

To file a claim for a benefit, you should send written notice to the Claims Administrator/Insurer. The notice need only identify the claimant and the Policyholder or covered employer. When the Claims Administrator/Insurer receives the notice, they will send a proof of claim form to you. You should receive the proof of claim form within 15 days of the date the Claims Administrator/Insurer received the notice of claim. If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form. Proof of claim must be sent within 180 days of the loss.

If a notice or proof is sent later than the times shown above, the Claims Administrator/Insurer will not deny or reduce a claim if the notice or proof was sent as soon as possible. The maximum time period to submit a proof of claim is one year from the date of the loss.

Claims for Benefits Under Life and Accidental Death and Dismemberment Plans

The Claims Administrator/Insurer will make an initial determination on life insurance claims within 90 days of receipt of due proof of loss. This period may be extended for up to an additional 90 days if special circumstances require an extension and the Claims Administrator/Insurer notifies you of the extension in writing before the end of the initial 90 day review period.

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review. You have 60 days to file an appeal of a denial of your claim. You may review pertinent documents and submit issues and comments in writing.

The Claims Administrator/Insurer will make a final decision no more than 60 days. This period may be extended for up to an additional 60 days if special circumstances (such as the need to hold a hearing) require an extension and the Claims Administrator/Insurer notifies you of the extension in writing before the end of the initial 60 day review period.