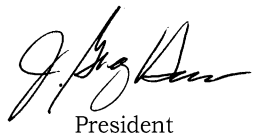
GROUP INSURANCE CERTIFICATE

STANDARD INSURANCE COMPANY certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy. Possession of this Certificate does not necessarily mean you are insured.



President

Revised 11/17/2023

GROUP POLICY NUMBER	608009
NAME OF POLICYHOLDER	PROFESSIONAL ENGINEERS IN CALIFORNIA GOVERNMENT
TYPE OF COVERAGE	LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, AND DEPENDENTS LIFE INSURANCE
GROUP POLICY EFFECTIVE DATE	May 1, 1990
GROUP POLICY DELIVERED IN	California and governed by the laws of that state.

IMPORTANT: PLEASE READ THIS

You are insured only if you meet the requirements in Part 2. BECOMING INSURED. You will remain insured only until your insurance ends, as explained in Part 3. WHEN INSURANCE ENDS.

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, Standard will provide the Policyholder with a notice for you.

This policy includes an Accelerated Benefit. Death Benefits will be reduced if an Accelerated Benefit is paid. The receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. However, if you meet the definition of "terminally ill individual" according to the Internal Revenue Code Section 101, your Accelerated Benefit may be non-taxable. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate has a Table of Contents to help you find specific provisions. **Defined terms are printed in all capital letters.**

GC186-LIFE

IMPORTANT NOTICE

To

MEMBERS insured under the GROUP POLICY

issued by STANDARD to the POLICYHOLDER

Effective April 1, 1998, the GROUP POLICY has been endorsed if the GROUP POLICY includes (a) ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, and (b) DEPENDENTS LIFE INSURANCE. The endorsement will not become effective if the GROUP POLICY does not contain both (a) and (b).

1. The ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section has been endorsed to add the following benefits:

Career Adjustment Benefit: The tuition expenses for training incurred by your SPOUSE DEPENDENT within 36 months after the date of your death, exclusive of room and board, but not to exceed $5,000 per year, or a cumulative total of $10,000 or 25% of the amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, whichever is less.

Standard will pay the Career Adjustment Benefit to your SPOUSE DEPENDENT if all of the following requirements are met:

1. You and your SPOUSE DEPENDENT are both insured under the GROUP POLICY.
2. You die as a result of an accident for which an ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE benefit is payable for loss of your life.
3. Your SPOUSE DEPENDENT is, within 36 months after the date of your death, registered and in attendance at a professional or trades training program for the purpose of obtaining employment or increasing earnings.

No Career Adjustment Benefit will be paid if you have no surviving SPOUSE DEPENDENT.

Child Care Benefit: The total child care expense incurred by your SPOUSE DEPENDENT within 36 months after your death for all CHILD DEPENDENTS under age 13, but not to exceed $5,000 per year, or a cumulative total of $10,000 or 25% of the amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, whichever is less.

Standard will pay a Child Care Benefit to your SPOUSE DEPENDENT if all of the following requirements are met:

1. You and your DEPENDENTS are insured under the GROUP POLICY.

2. You die as a result of an accident for which an ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE benefit is payable for loss of your life.

3. Your SPOUSE DEPENDENT pays a licensed child care provider who is not a member of your family for child care provided to your CHILD DEPENDENTS under age 13 within 36 months of your death.

4. The child care is necessary in order for your SPOUSE DEPENDENT to work or to obtain training for work or to increase earnings.

No Child Care Benefit will be paid if you have no surviving SPOUSE DEPENDENT.

Higher Education Benefit: The tuition expenses incurred per CHILD DEPENDENT within 48 months after your death at an accredited institution of higher education, exclusive of room and board, but not to exceed $5,000 per year, or a cumulative total of $20,000 or 25% of the amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, whichever is less.

Standard will pay a Higher Education Benefit to your CHILD DEPENDENT if all of the following requirements are met:

1. You and your CHILD DEPENDENTS are insured under the GROUP POLICY.

2. You die as a result of an accident for which an ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE benefit is payable for loss of your life.

3. Your CHILD DEPENDENT is, within 12 months after the date of your death, registered and in full-time attendance at an accredited institution of higher education beyond high school.

The Higher Education Benefit will be paid annually to each CHILD DEPENDENT who meets the requirements of item 3 above, for a maximum of 4 consecutive years beginning on the date of your death. No Higher Education Benefit will be paid if there is no CHILD DEPENDENT eligible to receive it.

2. The BENEFICIARY PROVISIONS section has been endorsed to add the following:

The Child Care Benefit, Career Adjustment Benefit and Higher Education Benefit will be paid as follows:

The Child Care Benefit will be paid to your surviving SPOUSE DEPENDENT. No Child Care Benefit will be paid if you have no SPOUSE DEPENDENT.

The Career Adjustment Benefit will be paid to your surviving SPOUSE DEPENDENT. No Career Adjustment Benefit will be paid if you have no SPOUSE DEPENDENT.

The Higher Education Benefit will be paid annually to each eligible CHILD DEPENDENT. No Higher Education Benefit will be paid if there is no CHILD DEPENDENT eligible to receive it.

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

  Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

  The basic coverage protections provided by the Association are as follows.

  - **Life Insurance, Annuities and Structured Settlement Annuities**

    For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

    - Life Insurance

      80% of death benefits but not to exceed $300,000
      80% of cash surrender or withdrawal values but not to exceed $100,000

    - Annuities and Structured Settlement Annuities

      80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

    The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

  - **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

The California Life and Health Insurance Guarantee Association
PO Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy at:

Standard Insurance Company
PO Box 2177
Portland, OR 97208-2177
(888) 937-4783

If the problem is not resolved, you may also write to the State of California at:

Department of Insurance
Consumer Services Division
300 S. Spring Street, 11th FL
Los Angeles, CA 90013
1-800-927-HELP (4357)

This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.

Table of Contents

Index of Defined Terms

OUTLINE OF YOUR LIFE INSURANCE AND YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

THIS OUTLINE IS INTENDED FOR USE WITH THIS CERTIFICATE AND CANNOT BE USED SEPARATELY AS A DESCRIPTION OF YOUR COVERAGE. OTHER PROVISIONS ARE FOUND IN THIS CERTIFICATE. PLEASE READ THIS CERTIFICATE CAREFULLY.

A. LIFE INSURANCE

TYPE OF INSURANCE - LIFE INSURANCE provides benefits to your BENEFICIARY if you die while insured under the GROUP POLICY.

LIFE INSURANCE BENEFITS - The amount of your LIFE INSURANCE is shown in Part 5.C.

EXCLUSIONS - Your SUPPLEMENTAL INSURANCE is subject to the Suicide Exclusion described in Part 5. B.

OTHER PROVISIONS - There is a CONTINUED LIFE INSURANCE benefit if you become TOTALLY DISABLED while insured and before your 60th birthday. See Part 5.D. You may have a RIGHT TO CONVERT to an individual policy of life insurance if your LIFE INSURANCE ends or is reduced. See Part 5.E.

B. ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

TYPE OF INSURANCE - ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE provides benefits to you or your BENEFICIARY for dismemberment or death resulting from ACCIDENTAL BODILY INJURIES.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS - The Maximum Amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE is shown in Part 6.C.

EXCLUSIONS AND LIMITATIONS - No benefit will be paid if either the ACCIDENTAL BODILY INJURIES or the loss is caused or contributed to by any of the excluded causes listed in Part 6.B. The accident must occur while you are insured under the GROUP POLICY. The loss must occur within 365 days after the accident.

BECOMING INSURED - Parts 2 and 3 explain when you become insured and when INSURANCE ends. The POLICYHOLDER determines the amount of your contribution toward the cost of your INSURANCE.

See the DEPENDENTS LIFE INSURANCE SUPPLEMENT for a description of the insurance available on the lives of your DEPENDENTS.

Part 1. GENERAL DEFINITIONS

STANDARD means Standard Insurance Company, Portland, Oregon.

EMPLOYER means State of California.

GROUP POLICY means STANDARD'S group policy number 608009 issued to the POLICYHOLDER.

INSURANCE means your insurance under the GROUP POLICY and includes your BASIC INSURANCE and your SUPPLEMENTAL INSURANCE.

LIFE INSURANCE means your life insurance under the GROUP POLICY and includes your BASIC LIFE INSURANCE and your SUPPLEMENTAL LIFE INSURANCE.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE means your accidental death and dismemberment insurance under the GROUP POLICY and includes your BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE and your SUPPLEMENTAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

SUPPLEMENTAL INSURANCE means your supplemental insurance under the GROUP POLICY, including the "Supplemental" plan and the "Supplemental Plus" plan.

DEPENDENTS LIFE INSURANCE means the life insurance for your DEPENDENTS under the GROUP POLICY.

SICKNESS means your sickness, illness or disease.

PREGNANCY means your pregnancy, childbirth or related medical conditions.

ACCIDENTAL BODILY INJURY means an injury to your body caused by an accident.

Providing EVIDENCE OF INSURABILITY, if required, means you must:

1. Complete and sign a health and medical history form provided by STANDARD;
2. Sign STANDARD'S form authorizing STANDARD to obtain information about your health; and
3. Provide any additional information about your insurability reasonably required by STANDARD.

All required information must be provided to STANDARD at your expense.

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Part 2. BECOMING INSURED

To become insured you must meet each of the following requirements plus the ACTIVE WORK requirement:

1. You must be a MEMBER.
2. You must be eligible for INSURANCE.
3. You must apply for SUPPLEMENTAL INSURANCE if you wish to be insured for SUPPLEMENTAL INSURANCE.
4. You must submit and have approved EVIDENCE OF INSURABILITY if required.

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A. DEFINITION OF MEMBER

You must be a MEMBER. You are a MEMBER if you are one of the following:

1. A member in good standing of Professional Engineers in California Government (P.E.C.G.), who is considered in employment status by the State of California, and is regularly scheduled to work at least 20 hours each week;

2. A member in good standing of Professional Engineers in California Government (P.E.C.G.), who is considered in retirement status by the State of California; or

3. A person defined in the POLICYHOLDER'S bylaws as a "Benefit Member".

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B. ELIGIBILITY FOR INSURANCE

You must be eligible for INSURANCE. You are eligible for INSURANCE on the later of (A) the effective date of the GROUP POLICY, and (B) the date you become a MEMBER.

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C. APPLICATION FOR INSURANCE

If you wish to be insured for SUPPLEMENTAL INSURANCE, you must apply for SUPPLEMENTAL INSURANCE and agree to make the required contributions to the Government Employee Insurance Benefit Trust (G.E.I.B.T.) by signing a completed enrollment card. You pay the entire cost of your SUPPLEMENTAL INSURANCE.

D. EVIDENCE OF INSURABILITY

You must provide STANDARD with satisfactory EVIDENCE OF INSURABILITY if you apply for SUPPLEMENTAL INSURANCE more than 90 days after you are first employed by the State of California. Additionally, you must submit satisfactory EVIDENCE OF INSURABILITY to become insured for any amount of SUPPLEMENTAL INSURANCE under the "Supplemental Plus" plan or to increase the amount of your INSURANCE under that plan.

E. EFFECTIVE DATE OF INSURANCE

If you meet the requirements of A and B, your BASIC INSURANCE will become effective on the first day of the calendar month following the month in which your dues are deducted from your pay, provided that you meet the ACTIVE WORK requirement on that date.

Your SUPPLEMENTAL INSURANCE will become effective on the latest of the following dates, provided that you meet the ACTIVE WORK requirement on that date:

(1) The date your BASIC INSURANCE becomes effective.

(2) The date you apply for SUPPLEMENTAL INSURANCE.

(3) The date STANDARD approves your EVIDENCE OF INSURABILITY, if (a) you applied for SUPPLEMENTAL INSURANCE more than 90 days after you were first eligible or (b) you wish to become insured under the "Supplemental Plus" plan.

Increases in the amount of your SUPPLEMENTAL INSURANCE under the "Supplemental Plus" plan will become effective on the date STANDARD approves your EVIDENCE OF INSURABILITY with respect to such increase, provided that you meet the ACTIVE WORK requirement on that date.

F. TRANSFER PROCEDURES

You will not be required to submit EVIDENCE OF INSURABILITY to become insured under the GROUP POLICY if you transfer your coverage from California State Employees Association (C.S.E.A.) to P.E.C.G., provided that:

(1) The amount of your INSURANCE under the GROUP POLICY does not exceed the amount of your insurance in effect on the date preceding transfer.

(2) You have submitted a recent payroll warrant slip showing the premium deductions for your insurance under C.S.E.A.

(3) You have submitted a Notice of Personnel Action Report of Appointment which shows proof of the change of your bargaining unit.

(4) All required transfer information has been received within 90 days following your transfer.

G. ACTIVE WORK REQUIREMENT (DOES NOT APPLY TO RETIRED MEMBERS)

If you were DISABLED on the day before the scheduled effective date of your INSURANCE, then the effective date of your INSURANCE will be delayed until the first day after you complete one full day of ACTIVE WORK.

For purposes of this ACTIVE WORK requirement, you are DISABLED if you are unable, as a result of SICKNESS, ACCIDENTAL BODILY INJURY, or PREGNANCY, to perform the material duties of your own occupation.

ACTIVE WORK and ACTIVELY AT WORK mean performing the usual duties of your job at your EMPLOYER'S designated place of business.

This ACTIVE WORK requirement also applies to any increase in your INSURANCE.

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Part 3. WHEN INSURANCE ENDS

Your INSURANCE will end automatically on the earliest of the following dates:

a. The last day of the calendar month in which you cease to be a MEMBER as defined in Part 2.A. or the last day of the last period for which the required premium payments were made for your INSURANCE, whichever is later.

b. The date you become a full time member of the armed forces of any country.

c. The last day of the calendar month in which P.E.C.G. dues were deducted from your pay.

d. With respect to SUPPLEMENTAL INSURANCE, the last day of the last period for which the required premium contribution was deducted from your pay.

e. The date the GROUP POLICY terminates.

f. The last day of the calendar month in which you cease to be ACTIVELY AT WORK for your EMPLOYER on your regular work days because of a general work stoppage (including a strike or lockout) resulting from a labor dispute between your collective bargaining unit and your EMPLOYER, unless your INSURANCE continues under the Strike Continuation Provision below.

g. With respect to your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, the date your claim for CONTINUED LIFE INSURANCE is approved by STANDARD.

h. The last day of the calendar month in which you cease to be ACTIVELY AT WORK for your EMPLOYER on your regular work days. However, your INSURANCE may be continued (unless it ends under items a. through i. above) during the following periods while you are absent from ACTIVE WORK:

(1) While you are receiving full salary (including sick pay) from your EMPLOYER;

(2) While you are unable to be ACTIVELY AT WORK as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, but not beyond the date your employment is terminated by you or your EMPLOYER;

(3) During a leave of absence if continuation of your INSURANCE under the GROUP POLICY is required by the state-mandated family or medical leave act or law;

(4) During any other leave of absence approved by your EMPLOYER; and

(5) While you are a Retired MEMBER, subject to the following conditions:

(a) You must be participating in the EMPLOYER'S retirement program;

(b) You must be a member in good standing of P.E.C.G.;

(c) You are not eligible for CONTINUED LIFE INSURANCE;

(d) The required premium contributions must be deducted from your pension; and

(e) Your INSURANCE will end on the date you cease to fulfill the requirements of (a), (b), (c), or (d) above.

STRIKE CONTINUATION PROVISION:

Your INSURANCE may continue for not more than six months while you are absent from ACTIVE WORK because of a general work stoppage (including a strike or lockout) resulting from a labor dispute between your EMPLOYER and your collective bargaining unit, subject to the following rules:

1. STANDARD must receive the required premium payment for BASIC INSURANCE from the POLICYHOLDER in accordance with the terms of the GROUP POLICY.

2. You must pay the entire premium for your INSURANCE (except BASIC INSURANCE) to G.E.I.B.T. as each premium comes due during the work stoppage.

3. Your INSURANCE during a work stoppage will end on the earliest of the following dates:

(a) On any premium due date, if you fail to make the required premium payment to your collective bargaining unit on or before that date.

(b) On the date when you have been absent from ACTIVE WORK for six months.

(c) On the date you begin full time employment with another employer.

(d) At the option of STANDARD, on any premium due date, if less than 75% of the MEMBERS eligible to continue their INSURANCE make the required premium payment to G.E.I.B.T.

C0309N

Part 4. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You may become insured again under the GROUP POLICY after your INSURANCE ends. The general rule is that you may become insured again on the same basis as a new MEMBER, as provided in Part 2. BECOMING INSURED. However, for purposes of becoming insured again, the requirements of Part 2 will be modified in specific situations as follows:

1. If your SUPPLEMENTAL INSURANCE ends because the required premium contribution is not made, you must submit EVIDENCE OF INSURABILITY satisfactory to STANDARD before becoming insured for SUPPLEMENTAL INSURANCE again.

2. If your INSURANCE ends because you cease to be a MEMBER, and you become a MEMBER again within 90 days after your INSURANCE ends, you will be immediately eligible for INSURANCE. You will not be required to provide EVIDENCE OF INSURABILITY to become insured again for SUPPLEMENTAL INSURANCE if:

   (a) You apply within 90 days after you become eligible; and

   (b) You apply for an amount that is equal to or less than the amount of your SUPPLEMENTAL INSURANCE which ended; and

   (c) You did not exercise your RIGHT TO CONVERT.

3. If your INSURANCE ends because you are on a federal or state mandated family or medical leave of absence, and you become a MEMBER again immediately following the period allowed, your INSURANCE will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

If you exercised your RIGHT TO CONVERT to an individual policy of life insurance when your LIFE INSURANCE ended, you must provide STANDARD with satisfactory EVIDENCE OF INSURABILITY to become insured again for LIFE INSURANCE or ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE under the GROUP POLICY.

Your INSURANCE will become effective again on the date determined from Part 2, and will not be retroactive to the date your INSURANCE ended.

C0409M

Part 5. LIFE INSURANCE

A. INSURING CLAUSE

Subject to all the terms of the GROUP POLICY, STANDARD will pay the amount of LIFE INSURANCE shown in C of this Part 5 upon receipt of satisfactory written proof of your death while you were insured under the GROUP POLICY.

B. SUICIDE EXCLUSION

If your death is caused or contributed to by suicide or any other intentionally self-inflicted injury committed while sane or insane, the amount of LIFE INSURANCE paid will be limited as follows:

Until your SUPPLEMENTAL LIFE INSURANCE has been in effect for two years, STANDARD'S sole liability with respect to your SUPPLEMENTAL LIFE INSURANCE will be to pay an amount equal to the premiums you paid for your SUPPLEMENTAL LIFE INSURANCE.

This exclusion also applies to any increase in your SUPPLEMENTAL LIFE INSURANCE, until the increase has been in effect for two years. STANDARD'S sole liability with respect to the increased amount will be to pay an amount equal to the premiums you paid for the increased amount.

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C. SCHEDULE OF LIFE INSURANCE

The amount of your LIFE INSURANCE is determined from the following table:

BASIC LIFE INSURANCE

Classification	Amount
Active Members:	$10,000
Retired Members under age 70	$1,500
Retired Members age 70 or over	None

Reductions In Insurance:

Active Members: If you reach an age shown below, the amount of insurance will be the amount determined from the Schedule Of Life Insurance, multiplied by the appropriate percentage below:

Your Age as of the preceding October 1st:	Percentage:
70 or over	65%

SUPPLEMENTAL LIFE INSURANCE

"Supplemental" plan:

Your age as of the preceding October 1st:	Amount:
Under age 65	$26,000
Age 65 through 69	13,000
Age 70 through 74	7,000
Age 75 or over	4,000

"Supplemental Plus" plan:

Amount: You may elect any multiple of $15,000, not to exceed $495,000.

Reductions In Insurance:

If you reach an age shown below, the amount of insurance will be the amount elected, multiplied by the appropriate percentage below:

Your Age as of the preceding October 1st:	Percentage:
65 through 69	50%
70 through 74	25%
75 or over	15%

Note that you must be insured under the "Supplemental" plan to become insured under the "Supplemental Plus" plan.

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EFFECTIVE DATE OF CHANGES IN AMOUNT OF LIFE INSURANCE:

Changes in the amount of your LIFE INSURANCE because of changes in your age or plan selection become effective on the date of such change. However, you must meet the ACTIVE WORK requirement and any EVIDENCE OF INSURABILITY requirement in Part 2. before any increase in the amount of your LIFE INSURANCE will become effective.

C05B9R

D. CONTINUED LIFE INSURANCE DURING TOTAL DISABILITY

If you become TOTALLY DISABLED while insured under the GROUP POLICY and before your 60th birthday, your LIFE INSURANCE will be continued while you remain continuously TOTALLY DISABLED, but not beyond the end of the calendar month in which you become 65 years of age. No premiums will be charged for the LIFE INSURANCE which is continued while you are TOTALLY DISABLED. This benefit, called CONTINUED LIFE INSURANCE, is subject to the following provisions:

1. DEFINITION OF TOTAL DISABILITY

   You are TOTALLY DISABLED if you are unable, as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, to perform the material duties of any occupation for which you are or become reasonably fitted by your education, training or experience.

2. AMOUNT OF CONTINUED LIFE INSURANCE

   The amount of your CONTINUED LIFE INSURANCE will be the amount of your LIFE INSURANCE in force on the date you become TOTALLY DISABLED. This amount will not change while you remain TOTALLY DISABLED.

   The amount of your CONTINUED LIFE INSURANCE will not be affected by the termination or amendment of the GROUP POLICY after the date you become TOTALLY DISABLED.

   If you receive an ACCELERATED BENEFIT, CONTINUED LIFE INSURANCE will be reduced according to the ACCELERATED BENEFIT provision.

3. TIME LIMITS ON PROVIDING PROOF OF TOTAL DISABILITY

To claim CONTINUED LIFE INSURANCE you (or in the event of your death, your BENEFICIARY) must provide to STANDARD satisfactory written proof of your continuous TOTAL DISABILITY within 12 months after the end of the last period for which premiums were paid for your LIFE INSURANCE.

If your claim for CONTINUED LIFE INSURANCE is approved, STANDARD will require satisfactory written proof of continuing TOTAL DISABILITY at reasonable intervals, but not more often than once a year after you have been continuously TOTALLY DISABLED for two years.

All proof of TOTAL DISABILITY must be provided to STANDARD at your expense.

4. REFUND OF PREMIUMS

Upon receipt of satisfactory written proof that you qualify for CONTINUED LIFE INSURANCE and that you have been continuously TOTALLY DISABLED for four or more months, STANDARD will refund to the POLICYHOLDER all premiums paid for your LIFE INSURANCE while you qualified for CONTINUED LIFE INSURANCE. However, if you qualified for CONTINUED LIFE INSURANCE for more than a year before you provided STANDARD with proof of loss in support of your claim, premiums paid for your LIFE INSURANCE prior to that one year period will not be refunded.

If you die during the first four months of continuous TOTAL DISABILITY, all premiums paid for that period will be refunded.

5. INDEPENDENT EXAMINATION

STANDARD has the right to have you examined at STANDARD'S expense at reasonable intervals while you are claiming CONTINUED LIFE INSURANCE coverage. Any such examination will be conducted by one or more physicians or vocational specialists of STANDARD'S choice.

6. WHEN CONTINUED LIFE INSURANCE ENDS

Your CONTINUED LIFE INSURANCE will end automatically on the earliest of the following dates:

(a) The date you cease to be TOTALLY DISABLED.

(b) The last day of the calendar month in which you have become 65 years of age.

(c) 90 days after the date STANDARD mails you a request for proof of your continued TOTAL DISABILITY, unless you provide STANDARD with the required proof within that 90 day period.

(d) The date you fail to provide STANDARD with a reasonable opportunity to have you independently examined at STANDARD'S expense.

(e) The effective date of any individual policy of life insurance issued to you when you exercise your RIGHT TO CONVERT under E of this Part 5.

7. EFFECT OF EXERCISING THE RIGHT TO CONVERT

You are not eligible for CONTINUED LIFE INSURANCE after you exercise your RIGHT TO CONVERT under E of this Part 5.

C05C3AX

E. RIGHT TO CONVERT TO AN INDIVIDUAL POLICY OF LIFE INSURANCE

If your LIFE INSURANCE coverage ends or is reduced, you may have a right to buy an individual policy of life insurance without submitting EVIDENCE OF INSURABILITY. You have this right, called the RIGHT TO CONVERT, within 90 days after one of the following dates:

1. The date your LIFE INSURANCE ends for any reason other than (a) your failure to make the required premium contribution, (b) the termination of the GROUP POLICY before your LIFE INSURANCE has been in force for five or more years, (c) payment of an ACCELERATED BENEFIT, or (d) an amendment of the GROUP POLICY so as to terminate the LIFE INSURANCE of any class of insured MEMBERS before your LIFE INSURANCE has been in force for five or more years.

2. The date your CONTINUED LIFE INSURANCE ends, unless you are eligible for LIFE INSURANCE under the GROUP POLICY on that date.

3. The date your LIFE INSURANCE is reduced because of a change in your age or classification.

4. The date your LIFE INSURANCE ends or is reduced because of the termination of the GROUP POLICY or an amendment to the GROUP POLICY which reduces or terminates the LIFE INSURANCE on any class of insured MEMBERS, provided that either (a) your LIFE INSURANCE has been in force for five or more years on that date or (b) you are TOTALLY DISABLED on that date and you became TOTALLY DISABLED while you were age 60 or over and while your LIFE INSURANCE was in force.

If you have a RIGHT TO CONVERT, the maximum amount you have a RIGHT TO CONVERT is the amount of your LIFE INSURANCE which ended, except as follows: If the GROUP POLICY terminated or was amended so as to reduce or terminate the LIFE INSURANCE on any class of insured MEMBERS, the maximum amount you have a RIGHT TO CONVERT is the lesser of the following amounts:

(i) The amount of your LIFE INSURANCE which ended, reduced by the amount of any other group life insurance you become eligible for during the CONVERSION PERIOD, and

(ii) $2,000. However, if you are TOTALLY DISABLED on that date as described in 4(b) above, the maximum you have a RIGHT TO CONVERT will not be limited by this $2,000 amount.

CONVERSION PERIOD means the 90 day period during which you can exercise the RIGHT TO CONVERT.

You must exercise your RIGHT TO CONVERT before the end of the CONVERSION PERIOD by both (a) applying to STANDARD in writing for an individual policy of life insurance and (b) paying STANDARD the first premium for the individual policy of life insurance.

If you exercise your RIGHT TO CONVERT, the individual policy of life insurance will become effective on the day after the end of your CONVERSION PERIOD.

If you die during the CONVERSION PERIOD, STANDARD will pay a death benefit equal to the maximum amount of life insurance you had a RIGHT TO CONVERT, whether or not you applied for an individual policy. The death benefit will be paid in accordance with the Beneficiary Provisions of the GROUP POLICY.

THE INDIVIDUAL POLICY OF LIFE INSURANCE

If you exercise your RIGHT TO CONVERT, you may not select a term insurance policy or a life insurance policy with disability or accidental death benefits, or any other additional benefits. With these limitations, you may select any form of individual life insurance policy then being issued by STANDARD to persons of your age and for the amount you wish to convert. You may apply for less than the maximum amount shown

above, but if you do you may not apply for less than the minimum amount being issued by STANDARD for the form of life insurance you select.

The premium for the individual life insurance policy will be determined from STANDARD'S published rates for standard risks.

C05D9E

F. ACCELERATED BENEFIT

If you qualify for CONTINUED LIFE INSURANCE and give us satisfactory proof of having a QUALIFYING MEDICAL CONDITION while you are insured under the GROUP POLICY, you may have the right to receive during your lifetime a portion of your INSURANCE as an ACCELERATED BENEFIT. You must have at least $10,000 of INSURANCE in effect to be eligible.

If your INSURANCE is scheduled to end within 24 months following the date you apply for the ACCELERATED BENEFIT, you will not be eligible for the ACCELERATED BENEFIT.

QUALIFYING MEDICAL CONDITION means you are terminally ill, as a result of an illness or physical condition which is reasonably expected to result in death within 12 months.

We may have you examined at our expense in connection with your claim for an ACCELERATED BENEFIT. Any such examination will be conducted by one or more PHYSICIANS of our choice.

1. Application For ACCELERATED BENEFIT

   You must apply for an ACCELERATED BENEFIT. To apply you must give STANDARD satisfactory proof that you have incurred a QUALIFYING MEDICAL CONDITION on our forms. Proof must include a statement from a PHYSICIAN that you have a QUALIFYING MEDICAL CONDITION.

2. Amount Of ACCELERATED BENEFIT

   (a) You may receive an ACCELERATED BENEFIT of up to 75% of your INSURANCE. The maximum ACCELERATED BENEFIT is $500,000. The minimum ACCELERATED BENEFIT is $5,000 or 10% of your INSURANCE, whichever is greater.

   (b) If the amount of your INSURANCE is scheduled to reduce within 24 months following the date you apply for the ACCELERATED BENEFIT, your ACCELERATED BENEFIT will be based on the reduced amount.

   The ACCELERATED BENEFIT will be paid to you once in your lifetime in a lump sum. If you recover from your QUALIFYING MEDICAL CONDITION after receiving an ACCELERATED BENEFIT, STANDARD will not ask you for a refund.

3. Effect On INSURANCE And Other Benefits

   For any purpose other than premium payment, the amount of your INSURANCE after payment of the ACCELERATED BENEFIT will be the greater of the amounts in (1) and (2) below; however, if you assign your rights under the GROUP POLICY, the amount of your INSURANCE will be the amount in (2) below.

   (1) 10% of the amount of your INSURANCE as if no ACCELERATED BENEFIT had been paid; or

   (2) The amount of your INSURANCE as if no ACCELERATED BENEFIT had been paid; minus

   The amount of the ACCELERATED BENEFIT; minus

   An interest charge calculated as follows:

   A times B times C divided by 365 = interest charge.

   A = The amount of the ACCELERATED BENEFIT.

B = The monthly average of our variable policy loan interest rate.

C = The number of days from payment of the ACCELERATED BENEFIT to the earlier of (1) the date you die, and (2) the date you have a RIGHT TO CONVERT.

Your AD&D INSURANCE, if any, is not affected by payment of the ACCELERATED BENEFIT.

4. Exclusions

No ACCELERATED BENEFIT will be paid if:

a. All or part of your INSURANCE must be paid to your child(ren), or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.

b. You are married and live in a community property state unless you give STANDARD a signed written consent from your spouse.

c. You have made an assignment of all or part of your INSURANCE unless you give STANDARD a signed written consent from the assignee.

d. You have filed for bankruptcy, unless you give STANDARD written approval from the Bankruptcy Court for payment of the ACCELERATED BENEFIT.

e. You are required by a government agency to use the ACCELERATED BENEFIT to apply for, receive, or continue a government benefit or entitlement.

f. You have previously received an ACCELERATED BENEFIT under the GROUP POLICY.

5. Definitions For ACCELERATED BENEFIT

INSURANCE means your LIFE INSURANCE and SUPPLEMENTAL LIFE INSURANCE, if any, under the GROUP POLICY.

PHYSICIAN means a licensed M.D. or D.O., other than yourself, diagnosing and treating you within the scope of the license.

C05E2BX

Part 6. ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. INSURING CLAUSE

Subject to all the terms of the GROUP POLICY, STANDARD will pay the amount shown in the Schedule of ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE upon receipt of satisfactory written proof that you have sustained any of the losses shown in that Schedule, provided that all of the following conditions are met:

1. The loss must be caused solely and directly by ACCIDENTAL BODILY INJURIES and the loss must occur independently of all other causes;

2. The accident must occur while you are insured under the GROUP POLICY; and

3. The loss must occur within 365 days after the date of the accident.

B. EXCLUSIONS

Even though a loss results from ACCIDENTAL BODILY INJURIES, no payment will be made if either the ACCIDENTAL BODILY INJURIES or the loss is caused or contributed to by any of the following:

1. Insurrection, war or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict with organized forces of a military nature.
2. Suicide or any other intentionally self-inflicted injury, while sane or insane.
3. Committing or attempting to commit an assault or a felony or your active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot in the performance of your official duties.
4. The voluntary use or consumption of any poison, chemical compound or drug (including but not limited to prescribed medications), unless used or consumed in accordance with the directions of a physician.
5. Any SICKNESS or PREGNANCY existing at the time of the accident.
6. Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction).
7. Medical or surgical treatment for any 1 through 6 above.

C06B1E

C. SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

1. MAXIMUM AMOUNT

The Maximum Amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE is determined from the following table:

Classification	Maximum Amount
BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	
Active Members:	$5,000

Reductions In Insurance:

Active Members: If you reach an age shown below, the amount of insurance will be the amount determined from the Schedule Of AD&D Insurance, multiplied by the appropriate percentage below:

Your Age as of the preceding October 1st:	Percentage:
70 or over	65%
SUPPLEMENTAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	

"Supplemental" plan:

Active Members:

Your Age as of the preceding October 1st:	Amount:
Under age 65	$26,000
Age 65 through 69	$13,000
Age 70 through 74	$7,000
Age 75 or over	$4,000

"Supplemental Plus" plan:

Active Members:

Amount: You may elect any multiple of $15,000, not to exceed $495,000.

Reductions In Insurance:

If you reach an age shown below, the amount of insurance will be the amount elected, multiplied by the appropriate percentage below:

Your Age as of the preceding October 1st:	Percentage:
65 through 69	50%
70 through 74	25%
75 or over	15%

Note that you must be insured under the "Supplemental" plan to become insured under the "Supplemental Plus" plan.

C06C3G

EFFECTIVE DATE OF CHANGES IN AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

Changes in the amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE because of changes in your age or plan selection become effective on the date of such change. However, you must meet the ACTIVE WORK requirement and any EVIDENCE OF INSURABILITY requirement in Part 2. before any increase in the amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE will become effective.

C06C9E

2. TABLE OF BENEFITS

Benefit for Accidental Loss of:

Life through PUBLIC TRANSPORTATION ACCIDENT…….	Two Times The Maximum Amount
Life through Other Accident……	Maximum Amount

Both Hands or Feet or Sight of Both Eyes.....	Maximum Amount
One Hand and One Foot.....	Maximum Amount
Either Hand or Foot and Sight of One Eye.....	Maximum Amount
Either Hand or Foot.....	One-Half The Maximum Amount
Sight of One Eye.....	One-Half The Maximum Amount

Loss of a hand or a foot means permanent severance of the hand or foot from the body at or above the wrist or ankle joint; loss of sight of an eye means entire and irrecoverable loss of sight.

PUBLIC TRANSPORTATION ACCIDENT means an accident occurring while you are a fare-paying passenger on PUBLIC TRANSPORTATION. PUBLIC TRANSPORTATION means a vehicle operated by a common carrier for the purpose of providing transportation for fare- paying members of the general public. Examples include, but are not limited to, buses, trains, boats, and planes operating on regular routes and selling tickets to members of the general public.

No more than the Maximum Amount of your ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE will be paid for all losses resulting from one accident, except that in the case of loss of life through PUBLIC TRANSPORTATION ACCIDENT no more than two times the Maximum Amount will be paid.

C06C4B

Part 7. PAYMENT OF CLAIMS

A. PAYMENT OF BENEFITS

All death benefits will be paid in accordance with the Beneficiary Provisions in G of this Part 7.

All Accidental Dismemberment benefits and ACCELERATED BENEFITS will be paid to you. Any Accidental Dismemberment benefits remaining unpaid at your death will be paid in accordance with the Beneficiary Provisions in G of this Part 7.

B. TIME LIMITS FOR FILING A CLAIM

All benefits must be claimed within 90 days after the date of loss or as soon thereafter as reasonably possible and, in any case, within one year after the end of that 90 day period. Claims not filed within these time limits will be denied and no benefit will be paid. These time limits will not apply during any period when the claimant lacked the legal capacity to file a claim.

C. FILING A CLAIM

All claims for benefits should be submitted on STANDARD'S forms. You should obtain claim forms from the POLICYHOLDER or the Plan Administrator.

You may also request claim forms from STANDARD. If STANDARD fails to provide you with claim forms within 15 days of your request you may submit your claim in a letter stating the occurrence, character and extent of the event for which the claim is made.

D. PROOF OF LOSS

Satisfactory written proof of loss in connection with a claim for benefits must be provided to STANDARD at the expense of the person claiming the benefits.

No benefits will be paid until STANDARD has received satisfactory written proof of loss in connection with the claim for benefits.

E. INVESTIGATION OF YOUR CLAIM

STANDARD has the right to conduct an independent investigation of any claim for benefits under the GROUP POLICY. No benefits will be paid until STANDARD has had a reasonable time to conduct an investigation.

F. INDEPENDENT EXAMINATION AND AUTOPSY

STANDARD has the right to have you examined at STANDARD'S expense in connection with a claim for Accidental Dismemberment benefits. Any such examination will be conducted by one or more physicians or vocational specialists of STANDARD'S choice.

STANDARD has the right to have an autopsy performed at STANDARD'S expense, except where prohibited by law.

G. BENEFICIARY PROVISIONS

1. NAMING A BENEFICIARY

BENEFICIARY or BENEFICIARIES mean the person or persons you name to receive the death benefits under the GROUP POLICY if you die. You may name or change BENEFICIARIES at any time. The consent of a named BENEFICIARY is not needed to change BENEFICIARIES.

BENEFICIARY DESIGNATION means the written instrument in which you name or change your BENEFICIARY. Your written BENEFICIARY DESIGNATION must be dated and signed by you and delivered to the POLICYHOLDER during your lifetime. Your BENEFICIARY DESIGNATION will take effect on the date it is delivered to the POLICYHOLDER. The BENEFICIARY DESIGNATION must relate to the INSURANCE provided under the GROUP POLICY. If the GROUP POLICY replaces all or a part of the insurance provided by an earlier policy, a written BENEFICIARY DESIGNATION signed and dated by you under the earlier policy will be accepted as your BENEFICIARY DESIGNATION under the GROUP POLICY.

2. PAYMENT TO YOUR BENEFICIARY

Death benefits will be paid to your surviving BENEFICIARY or BENEFICIARIES in the highest class, with the classes ranking in the following order: primary, followed by first contingent, second contingent, etc. Two or more surviving BENEFICIARIES in the same class will share equally, unless you specify their respective shares.

Payment of death benefits to a BENEFICIARY in the amount of $10,000 or more will be made by deposit into a Standard Secure Access account. Standard Secure Access is an interest-bearing checking account in the name of the BENEFICIARY, as owner. The account is subject to the terms and conditions of a Confirmation Certificate which will be given to the BENEFICIARY. The funds are fully guaranteed by STANDARD.

If a BENEFICIARY chooses not to participate in the Standard Secure Access account described above, the amount payable to a BENEFICIARY may be paid in installments over a period of years upon

mutual agreement between STANDARD and the BENEFICIARY. To the extent permitted by law, the amount payable to a BENEFICIARY will not be subject to any legal process against the BENEFICIARY or to the claims of any creditor or creditor's representative.

3. BENEFICIARY MUST SURVIVE YOU

If a BENEFICIARY dies on the date of your death, or within 15 days after the date of your death, death benefits will be paid as if that BENEFICIARY had died before you, unless satisfactory proof of loss with respect to your death is delivered to STANDARD before the date of the BENEFICIARY'S death.

4. NO SURVIVING BENEFICIARY

If you do not name a BENEFICIARY, or if you are not survived by a BENEFICIARY, all death benefits will be paid in equal shares to the first surviving class of the following classes:

a. Your spouse.

b. Your children.

c. Your parents.

If none of them survives you, the benefits will be paid to your estate.

5. RELIANCE BY STANDARD

STANDARD may rely on an affidavit or other written evidence deemed satisfactory to STANDARD to determine the identity or the nonexistence of BENEFICIARIES not identified by name. Any payment made by STANDARD in good faith reliance on such evidence will fully discharge STANDARD to the extent of such payment.

H. NOTICE OF DECISION ON CLAIM

STANDARD will evaluate a claim for benefits promptly after STANDARD receives it. Within 90 days after STANDARD receives the claim STANDARD will send the claimant: (a) a written decision on the claim; or (b) a notice that STANDARD is extending the period to decide the claim for an additional 90 days.

If STANDARD extends the period to decide the claim, STANDARD will notify the claimant of the following: (a) the reasons for the extension; (b) when STANDARD expects to decide the claim; and (c) any additional information STANDARD needs to decide the claim.

If STANDARD requests additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, STANDARD may decide the claim based on the information STANDARD has received.

If STANDARD denies any part of the claim, STANDARD will send the claimant a written notice of denial containing:

a. The reasons for STANDARD'S decision.

b. Reference to the parts of the GROUP POLICY on which STANDARD'S decision is based.

c. A description of any additional information needed to support the claim.

d. Information concerning the claimant's right to a review of STANDARD'S decision.

e. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA, if the claim is denied on review.

I. REVIEW PROCEDURE

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial.

The claimant may send STANDARD written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. STANDARD'S review will include any written comments or other items the claimant submits to support the claim.

STANDARD will review the claim promptly after STANDARD receives the request. Within 60 days after STANDARD receives the request for review STANDARD will send the claimant: (a) a written decision on review; or (b) a notice that STANDARD is extending the review period for 60 days. If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If STANDARD extends the review period, STANDARD will notify the claimant of the following: (a) the reasons for the extension; (b) when STANDARD expects to decide the claim on review; and (c) any additional information STANDARD needs to decide the claim.

If STANDARD requests additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, STANDARD may conclude STANDARD'S review of the claim based on the information STANDARD has received.

If STANDARD denies any part of the claim on review, the claimant will receive a written notice of denial containing:

a. The reasons for STANDARD'S decision.

b. Reference to the parts of the GROUP POLICY on which STANDARD'S decision is based.

c. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

d. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The GROUP POLICY does not provide voluntary alternative dispute resolution options.

C0703R

Part 8. TIME LIMITS ON LEGAL ACTIONS AND CERTAIN DEFENSES

No action at law or in equity may be brought to recover under the GROUP POLICY until 60 days after written proof of loss has been provided to STANDARD.

Any statement you make to obtain INSURANCE will be a representation and not a warranty. No misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your INSURANCE unless:

(a) Your INSURANCE would not have been approved except for your misrepresentation;

(b) Your misrepresentation is contained in a written instrument signed by you; and

(c) A copy of the written instrument containing your misrepresentation has been given to you or your BENEFICIARY.

After your INSURANCE has been in effect for two years, no misrepresentation by you will be used to reduce or deny your claim or to deny the validity of your INSURANCE.

C0801I

Part 9. ASSIGNMENT

Your CERTIFICATE is not assignable. The INSURANCE provided and benefits payable are not assignable.

C0901B

Part 10. ALLOCATION OF AUTHORITY

Except for those functions which the GROUP POLICY specifically reserves to the POLICYHOLDER, STANDARD has full and exclusive authority to control and manage the GROUP POLICY, to administer claims, and to interpret the GROUP POLICY and resolve all questions arising in the administration, interpretation, and application of the GROUP POLICY.

STANDARD'S authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the GROUP POLICY and any claim under it;
3. The right to determine:
    a. Eligibility for INSURANCE;
    b. Entitlement to benefits;
    c. Amount of benefits payable;
    d. Sufficiency and the amount of information STANDARD may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the GROUP POLICY, any decision made in the exercise of STANDARD'S authority is conclusive and binding.

DEPENDENTS LIFE INSURANCE SUPPLEMENT

DEPENDENTS LIFE INSURANCE on the lives of your DEPENDENTS is governed by the following provisions:

A. DEFINITION OF DEPENDENT

DEPENDENT means a person, other than a full time member of the armed forces of any country, who is:

(1) SPOUSE DEPENDENT:

a. A person to whom you are legally married; or

b. Your Domestic Partner. Domestic Partner means an individual with whom you have established a domestic partnership in accordance with the laws or regulations of a jurisdiction that recognizes domestic partnerships; or an individual you have identified as a domestic partner under your Employer's domestic partnership policy, if applicable.

(2) CHILD DEPENDENT:

a. Your child from live birth until age 26.

b. Your adopted child until age 26.

c. Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.

d. A child living in your home for whom you are the court appointed legal guardian until age 26.

e. Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of mental or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

CDA01DX

B. EFFECTIVE DATE OF DEPENDENTS LIFE INSURANCE

You become eligible for DEPENDENTS LIFE INSURANCE on the lives of your DEPENDENTS on the later of the following dates:

(1) The date your SUPPLEMENTAL LIFE INSURANCE under the "Supplemental" plan becomes effective.

(2) The date you first acquire a DEPENDENT.

You must apply for DEPENDENTS LIFE INSURANCE and you must agree to make the required premium contributions to the POLICYHOLDER.

Your BASIC DEPENDENTS LIFE INSURANCE will become effective on the latest of the following dates:

(1) The date you are eligible for DEPENDENTS LIFE INSURANCE.

(2) The date you have applied for DEPENDENTS LIFE INSURANCE.

(3) The date each of your DEPENDENTS has submitted satisfactory EVIDENCE OF INSURABILITY, if you apply for DEPENDENTS LIFE INSURANCE more than 31 days after you are first eligible for DEPENDENTS LIFE INSURANCE.

A person who becomes your DEPENDENT while your BASIC DEPENDENTS LIFE INSURANCE is in effect is automatically insured for BASIC DEPENDENTS LIFE INSURANCE on the date the person becomes your DEPENDENT.

Your "Supplemental Plus" DEPENDENTS LIFE INSURANCE will become effective on the later of (a) the date your "Supplemental Plus" LIFE INSURANCE becomes effective, and (b) the date STANDARD approves EVIDENCE OF INSURABILITY for your SPOUSE DEPENDENT.

CDB09C

C. INSURING CLAUSE

Subject to the terms of the GROUP POLICY, STANDARD will pay the amount determined from the SCHEDULE OF DEPENDENTS LIFE INSURANCE immediately upon receipt of satisfactory written proof that an insured DEPENDENT of yours has died while your DEPENDENTS LIFE INSURANCE was in effect.

CDC02A

D. SCHEDULE OF DEPENDENTS LIFE INSURANCE

The amount of BASIC DEPENDENTS LIFE INSURANCE for each DEPENDENT is equal to the lesser of:

(1) One-half the amount of your LIFE INSURANCE; and

(2) The appropriate amount shown below:

SPOUSE DEPENDENT $5,000
CHILD DEPENDENT while under 6 months $500
CHILD DEPENDENT age 6 months and over.....$5,000

The amount of "Supplemental Plus" DEPENDENTS LIFE INSURANCE for a SPOUSE DEPENDENT is the amount selected by the MEMBER. The MEMBER may select any multiple of $15,000, not to exceed 50% of the total amount of LIFE INSURANCE on the life of the MEMBER.

A SPOUSE DEPENDENT must provide EVIDENCE OF INSURABILITY satisfactory to STANDARD before any increase in the amount of "Supplemental Plus" DEPENDENTS LIFE INSURANCE will become effective.

CDD01LX

E. BENEFICIARY

Death benefits under this Supplement will be paid to you if you are living. Otherwise, the death benefits will be paid in equal shares to the first surviving class of the following classes:

(1) Your spouse.

(2) Your children.

(3) Your parents.

If none of them is living, the death benefits will be paid to your estate.

CDE02A

F. CONTINUED COVERAGE WITHOUT PAYMENT OF PREMIUMS

Your DEPENDENTS LIFE INSURANCE will be continued in force without payment of premiums as follows:

(1) For five months after your death.

(2) During any period when you qualify for CONTINUED LIFE INSURANCE.

(3) During any period when your only insured DEPENDENT is a HANDICAPPED CHILD who qualifies for continued coverage under H. CONTINUED COVERAGE FOR A HANDICAPPED CHILD.

NOTE: DEPENDENTS LIFE INSURANCE on the life of any one of your DEPENDENTS will end on the date determined under G.2.

CDF01B

G. WHEN DEPENDENTS LIFE INSURANCE ENDS

1. Your DEPENDENTS LIFE INSURANCE will end automatically on the earliest of the following dates:

   a. Five months after the date of your death.

   b. The date your LIFE INSURANCE ends for any reason other than your death.

   c. The date your coverage under the SUPPLEMENTAL INSURANCE "Supplemental" plan ends.

   d. The date the GROUP POLICY terminates, unless your DEPENDENTS LIFE INSURANCE is continued in force under F(1) or F(2) above.

   e. On the last day of the last period for which you made the required contribution for your DEPENDENTS LIFE INSURANCE.

2. DEPENDENTS LIFE INSURANCE on the life of any one of your DEPENDENTS will end automatically on the earliest of the following dates:

   a. The date your DEPENDENTS LIFE INSURANCE ends.

   b. The date the DEPENDENT becomes a full time member of the armed forces of any country.

   c. The date the CHILD DEPENDENT becomes 26 years of age, except when coverage continues beyond that date for a HANDICAPPED CHILD.

   d. The date the SPOUSE DEPENDENT becomes divorced from you or your Domestic Partnership is terminated.

CDG09E

H. RIGHT TO CONVERT TO AN INDIVIDUAL POLICY

A DEPENDENT has the right to buy an individual life insurance policy, without submitting EVIDENCE OF INSURABILITY, if that DEPENDENT'S life insurance ends for any reason other than:

(1) The termination of the GROUP POLICY before your LIFE INSURANCE has been in force for five years; or

(2) Your failure to make the required contribution for DEPENDENTS LIFE INSURANCE.

The individual life insurance policy may be on any form, other than term insurance, then issued by STANDARD. The individual policy will not contain disability or accidental death benefits, or any other additional benefits. The maximum amount of individual life insurance will be the amount of the DEPENDENT'S life insurance which ended, except as follows: If the GROUP POLICY terminates after your

LIFE INSURANCE has been in force for five or more years, the maximum amount of the individual life insurance will be the lesser of (a) $2,000 and (b) the amount of DEPENDENT'S life insurance which ended, reduced by the amount of any other group dependent's life insurance coverage your DEPENDENT becomes eligible for during the 90 days after the termination of the GROUP POLICY. The premium for the individual life insurance policy will be determined from STANDARD'S published rates for standard risks.

The DEPENDENT must apply in writing for the individual policy and must pay the applicable premium to STANDARD within 90 days after the date of termination of the DEPENDENT'S life insurance. If the DEPENDENT dies during this 90 day period, STANDARD will pay the maximum amount of life insurance for which an individual policy could have been issued, whether or not the DEPENDENT had applied for an individual policy. The death benefit will be paid to the person entitled to payment under the Beneficiary provision in this Supplement.

If a CHILD DEPENDENT does not have the legal capacity to enter into a contract of insurance which is binding on both STANDARD and the CHILD DEPENDENT, the DEPENDENT'S parent or guardian must apply for the individual policy on the life of the DEPENDENT.

The DEPENDENT'S individual policy, if issued, will become effective on the 91st day after the date the DEPENDENT'S life insurance ended under this Supplement.

A DEPENDENT who has exercised the right to convert to an individual policy is not to be eligible for coverage again under your DEPENDENTS LIFE INSURANCE.

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