GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF:

THE PRESIDENT AND TRUSTEES OF WILLIAMS COLLEGE DBA WILLIAMS COLLEGE

ALL MEMBERS
Group Voluntary Term Life

Print Date: 09/22/2009
Summary Plan Description for Purposes of Employee Retirement Income Security Act (ERISA).

- This booklet-certificate (including any supplement) may be utilized in part in meeting the Summary Plan Description requirements under ERISA for insured employees (or those listed on the front cover) of the Policyholder who are eligible for Group Life insurance.

- A separate booklet-certificate will be issued if necessary to cover one or more separate classes of the Policyholder who are eligible for Group coverage. For further information, contact your plan administrator.
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Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

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

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. Please remove your enrollment material from your prior booklet, place it with this booklet, and destroy your prior booklet. If you have any questions about this new booklet, please contact your employer. In the event of future plan changes, you will be provided with a new Scheduled Benefits Summary, booklet-certificate or a booklet-certificate rider.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance. This booklet describes all the benefits available under the Group Policy underwritten by Us. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

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

We reserve complete discretion to construe or interpret the provisions of this group insurance, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such manners will be controlling, binding, and final as between Us and persons covered by this group insurance, subject to the Claim Procedures shown on page GH 146 A of this booklet.

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

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

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

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

PRINCIPAL LIFE INSURANCE COMPANY
Des Moines, IA 50392-0001
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This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

**MEMBER LIFE INSURANCE**

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

<table>
<thead>
<tr>
<th>Class</th>
<th>*Scheduled Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Members</td>
<td>The amount that is equal to 1, 2, 3, 4 or 5 times your Basic Annual Compensation (this amount will be rounded to the next higher $1,000, if it is not already an exact multiple of $1,000).</td>
</tr>
</tbody>
</table>

The Maximum Scheduled Benefit amount will not exceed the lesser of 5 times your Basic Annual Compensation or $1,000,000 (rounded to the next higher $1,000) subject to the reduction provision below. The Minimum Scheduled Benefit amount will be the greater of $10,000 or 1 times your Basic Annual Compensation (rounded to the next higher $1,000) subject to the reduction provision below.

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

* The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet on GH 115 A. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, your beneficiary will be paid the approved amount.

Effective on the July 1st following the date of your change in age, for the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below:

<table>
<thead>
<tr>
<th>Age</th>
<th>The percentage by which current amount of coverage (after all previous reductions) will be reduced to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65</td>
<td>18%</td>
</tr>
<tr>
<td>Age 70</td>
<td>35%</td>
</tr>
<tr>
<td>Age 75</td>
<td>35%</td>
</tr>
<tr>
<td>Age 80</td>
<td>25%</td>
</tr>
<tr>
<td>Age 85</td>
<td>25%</td>
</tr>
<tr>
<td>Age 90</td>
<td>25%</td>
</tr>
<tr>
<td>Age 95</td>
<td>25%</td>
</tr>
</tbody>
</table>

**DEPENDENT LIFE INSURANCE**

If one of your Dependents dies, you will be paid the Scheduled Benefit then in force for that Dependent. The specific Scheduled Benefit is shown on your Scheduled Benefits Summary and based on the status of the Dependent:

<table>
<thead>
<tr>
<th>Class</th>
<th>*Scheduled Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Members</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent</th>
<th>*Scheduled Benefit</th>
</tr>
</thead>
</table>
Spouse: An amount in increments of $10,000 as applied for by you and approved by Us.

Children (age at death):
- 14 days and older: $5,000

The Maximum Scheduled Benefit amount for your Dependent spouse will be $50,000 and the Minimum Scheduled Benefit amount for your spouse will be $10,000 subject to the reduction provision below.

* The Scheduled Benefit for your spouse is subject to the Proof of Good Health requirements as described in the booklet on GH 125 C. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, your beneficiary will be paid the approved amount.

A Dependent’s Scheduled Benefit will not exceed 50% of your Scheduled Benefit amount.
HOW TO BE INSURED - MEMBERS

MEMBER LIFE INSURANCE

Eligibility

To be eligible for insurance you must be a Member.

Member means any PERSON who is a Full-Time Employee of the Policyholder.

You will be eligible on the date you begin Active Work.

Effective Dates - Actively at Work

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

This Actively at Work requirement will be waived for Members who:

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

Individual Incontestability

All statements made by any insured person (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person’s insurance unless:

- the insurance has been in force for less than two years during the insured person’s lifetime; and
- the statement is in written form signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person’s beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person’s not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person’s age is misstated, We may, at any time, adjust premiums and benefits to reflect the correct age.

Assignments

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

Proof of Good Health

In some instances, Proof of Good Health will be required to place your insurance in force. The type and form of required proof will be determined by Us. You will need to file Proof of Good Health:

- If you request insurance more than 31 days after the date you are eligible including any insurance you refuse and later request. You must pay the cost of obtaining proof in this instance.
- If you have failed to provide required Proof of Good Health or you have been refused insurance under the Group Policy at any prior time. You must pay the cost of obtaining proof in this instance.

- If you elect to terminate insurance and, more than 31 days later, you request to be insured again. You must pay the cost of obtaining proof in this instance.

- To become insured, initially, for any Member Life Insurance Scheduled Benefit amount in excess of:
  - the lesser of 3 times Basic Annual Compensation or $300,000 if you are under age 70; and
  - the lesser of 3 times Basic Annual Compensation or $10,000 if you are age 70 or over.

  We will pay the reasonable cost of proof required in this instance.

- To become insured for any request for a Scheduled Benefit amount increase. We will pay the reasonable cost of proof required in this instance.

- To become insured for any Member Life Insurance Scheduled Benefit amount increase if any previous Scheduled Benefit increase has been declined. You must pay the cost of obtaining proof in this instance.

**Effective Date for Initial Insurance**

(Proof of Good Health Not Required)

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

Your insurance will normally be in force on:

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

- the date of your request, if you make your request within 31 days after the date you are eligible.

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

**Effective Date for Initial Insurance**

(Proof of Good Health Required)

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

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

- the date Proof of Good Health is approved by Us.

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

**Effective Date for Benefit Changes**

(Proof of Good Health Not Required)

If Proof of Good Health is not required, a change in your Scheduled Benefit amount because of a change in your status (compensation) will normally be effective on the date of the change in status. However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

If Proof of Good Health is not required, a change in the Scheduled Benefits because of a change in the schedule of insurance elected by the Policyholder will normally be effective on the date of change. However, if you are not Actively
at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

If Proof of Good Health is not required, a change in your Scheduled Benefit amount because of a request by you will normally be effective the January 1 that next follows the date of the request. However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

Exception: decreases in Member Life Insurance Scheduled Benefit amounts are effective on the date noted above whether or not you are Actively at Work.

**Effective Date for Benefit Changes**  
**(Proof of Good Health Required)**

If Proof of Good Health is required, a change in your Scheduled Benefit amount will normally be effective on the later of:

- the date the change would have been effective had Proof of Good Health not been required; or
- the date Proof of Good Health is approved by Us.

However, the exception noted above when Proof of Good Health is not required will also apply when Proof of Good Health is required.

**Termination**

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

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

**Termination for Fraud**

We may at any time terminate your eligibility under the Group Policy:

- In writing and with 31 day notice, if you submit any claim that contains false or fraudulent elements under state or federal law;
- In writing and with 31 day notice, upon finding in a civil or criminal case that you have submitted claims that contain false or fraudulent elements under state or federal law;
- In writing and with 31 day notice, when you have submitted a claim which, in good faith judgement and investigation, you knew or should have known, contains false or fraudulent elements under state or federal law.
Insurance While Outside of the United States

If you are outside the United States, your insurance will automatically terminate. However, you will continue to be eligible for benefits provided under the Group Policy if you are temporarily outside of the United States for one of the following reasons:

- travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or
- a business assignment; or
- Full-Time Student status, provided you are either:
  - enrolled and attending an accredited school in a foreign country; or
  - participating in an academic program in a foreign country, for which the institution of higher learning at which you are enrolled in the U.S. grants academic credit;

provided you are temporarily outside the United States for a period of six months or less.

Continuation

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

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

- For layoff, the date 90 days after the date Active Work ends; or
- For approved leave of absence or sabbatical, the date 12 months after the date Active Work ends.

Your insurance may also be continued under the continuation provisions described on GH 117 C and subject to the provisions of the Group Policy.

Your insurance may also be continued under the Portability provisions described on GH 304 and subject to the provisions of the Group Policy.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.
HOW TO BE INSURED - DEPENDENTS

DEPENDENT LIFE INSURANCE

Eligibility

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

- the date you are eligible for Member insurance; or
- the date you first acquire a Dependent.

Effective Date

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

- Insurance will not be effective unless you are insured for Member Insurance.
- If a Dependent spouse is in a Period of Limited Activity on the date initial Dependent Insurance would otherwise be effective, the Dependent will not insured until the Period of Limited Activity ends.
- For your spouse, to become insured, initially, for any Dependent Life Insurance Scheduled Benefit amount in excess of:
  - $50,000 if your spouse is under age 70; and
  - $10,000 if your spouse is age 70 or over.

  We will pay the reasonable cost of proof required in this instance.
- If a Dependent is confined in a Hospital or Skilled Nursing Facility on the date an increase in Dependent Life Insurance Scheduled Benefits would otherwise be effective, the increase will not be in force until the confinement ends.
- Any required Proof of Good Health will be with respect to the health of your Dependents.
- If Dependent insurance is then in force for any other Dependent, a new Dependent (other than a newborn child) will be insured on the date acquired, provided the new Dependent is not then confined in a Hospital or Skilled Nursing Facility.
- If Dependent insurance is then in force for any other Dependent, a newly born child will be insured on the date the child is 14 days old, provided the child meets the definition of a Dependent Child.

Individual Incontestability

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

Termination

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

- the date you cease to belong to a class for which Dependent insurance is provided; or
- the date Dependent Life Insurance is removed from the Group Policy; or
- the date the last premium is paid for your Dependent’s insurance; or
- any date desired, if requested by you before that date; or
- the date your Member insurance ceases; or
- for Dependent Life Insurance, the date you retire.

Insurance for any one Dependent will terminate on the date he or she ceases to be your Dependent.

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

**Termination for Fraud**

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

**Insurance While Outside of the United States**

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

**Continuation**

Your Dependent’s insurance may also be continued as described under the continuation provisions described on GH 117 C and subject to the provisions of the Group Policy.

Your Dependent’s insurance may also be continued under the portability provisions described on GH 304 and subject to the provisions of the Group Policy.
Continuation

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

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

FMLA and Other Continuation Provisions

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

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

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

Eligible Employer

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

Eligible Employee

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

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

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

Mandated Unpaid Leave

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

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

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

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

**Reinstatement**

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

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

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

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

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

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

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

See your employer for details on this reinstatement provision.
DESCRIPTION OF BENEFITS

MEMBER LIFE INSURANCE

Death Benefit

If you die while insured for Member Life Insurance, We will pay your beneficiary the Scheduled Benefit in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment and Accumulated Interest Charges as discussed later in this Section. If your beneficiary does not survive you, We will make payment in the following order of precedence:

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

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

Upon your death, the Scheduled Benefit in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment and Accumulated Interest Charges as discussed later in this Section will be placed in an interest-bearing draft account. The account balance will be available to your beneficiary at any time, in total or in part, as provided in the Group Policy.

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

We may pay, at Our option, a sum not exceeding $250 to any person appearing to be entitled to by reason of having incurred funeral or other expenses relating to your last illness or death.

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

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may later change your beneficiary by filing a written request with the Policyholder. In no event may a beneficiary be changed by a Power of Attorney. See the Policyholder for change request forms. A change in your beneficiary will not be in force until the Policyholder record(s) the change.

Continuation (Member Life Insurance - Coverage During Disability)

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Totally Disabled, you might qualify to continue your Member Life Insurance and Dependent Life Insurance. This continuation is called Coverage During Disability. This Coverage During Disability provision does not apply to you if you have continued coverage under the Portability provision, as described on GH 304.

To be qualified for Coverage During Disability, you must:
- become Totally Disabled while insured for Member Life Insurance; and
- become Totally Disabled before age 70; and
- remain Totally Disabled continuously; and
- be under the regular care and attendance of a Physician; and
- send proof of Total Disability to Us within one year of the date Total Disability starts and as often thereafter as We may require; and
- return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, We will refund premiums paid, less dividends and less any outstanding policy loan balance; and
- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician).

If you qualify, Coverage During Disability will be in force on the earlier of:
- the date your Total Disability begins; or
- the date of your death.

Premium will be charged for Member Life Insurance and Dependent Life Insurance while your Coverage During Disability is in force.

Coverage During Disability will cease on the earlier of:
- the date you are age 70; or
- the date you no longer qualify.

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

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

**Accelerated Benefit**

An Accelerated Benefit is an advance (before death) payment of a part of your Member Life Insurance benefit. To qualify for an Accelerated Benefit, you must:
- be insured for a Member Life Insurance benefit of at least $10,000; and
- be Terminally Ill (expected to die within 24 months or less); and
- send a request for Accelerated Benefit payment to Us; and
- send proof, satisfactory to Us, of your Terminal Illness.

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

You will be considered Terminally Ill if you have experienced a Qualifying Event and you are expected to die within 24 months or less of the date you request payment of Accelerated Benefits.

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

- coronary artery disease resulting in an acute infarction or requiring surgery;
- permanent neurological deficit resulting from cerebral vascular accident;
- end stage renal failure; or
- acquired immune deficiency syndrome (AIDS); or
- major organ transplant; or
- medical condition requiring continuous artificial life support.

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

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

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

When you make a claim for the lump sum payment of accelerated benefits, We will issue a revised schedule page to reflect the new, reduced in-force face amount of the underlying life insurance policy and future premiums.

If an Accelerated Benefit is paid, the Member Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by the sum of:

- Accelerated Benefit payment; plus
- Accumulated Interest Charges.

If an Accelerated Benefit is paid, the Member Accidental Death and Dismemberment Insurance benefit otherwise payable upon your death will not be reduced.

Accumulated Interest Charges will be the sum of interest charged for each day of the period from the date of your Accelerated Benefit payment to the date of your death, but not more than two years. This interest will be calculated by applying a daily rate (equivalent to 8% per year) to the amount of the Accelerated Benefit payment.

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

<table>
<thead>
<tr>
<th>BENEFIT EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Life Insurance Benefit Amount $ 100,000</td>
</tr>
<tr>
<td>Accelerated Benefit Amount Requested $ 75,000</td>
</tr>
</tbody>
</table>
(Member would receive $75,000)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accelerated Benefit paid on August 15</td>
<td></td>
</tr>
<tr>
<td>Member death occurs on November 15 (92 days after payment)</td>
<td></td>
</tr>
<tr>
<td>Accumulated Interest Charges ($75,000 x .08) x (92 days/365 days)</td>
<td>$ 1,512</td>
</tr>
<tr>
<td>Payment to Member’s Beneficiary ($100,000 - $75,000 - $1,512)</td>
<td>$ 23,488</td>
</tr>
</tbody>
</table>

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

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

**Individual Purchase Rights**

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

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

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

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

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

You must apply for individual purchase and pay the first premium to Us within 31 days after your coverage under the Group Policy ceases.

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

The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong on the individual policy’s date of issue.
In the event the Group Policy terminates or is amended to exclude your insurance class, We will provide Written notice of your individual purchase right within 15 days after insurance under the Group Policy terminates.

If notice is not given within the 15-day period, you must be given an additional 15 days after the date of such Written notice to apply for individual purchase.

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

DEPENDENT LIFE INSURANCE

Death Benefit

If one of your Dependents dies while insured for Dependent Life Insurance, We will pay the Scheduled Benefit in force for that Dependent, less any unpaid premium.

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

No payment will be made before We receive written proof of the Dependent’s death.

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

Individual Purchase Rights

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

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

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

- If Dependent Life Insurance for your Dependent ceases because your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount your Dependent may buy will be the amount of Dependent Life Insurance in force for the Dependent on the date of termination, less any individual amount purchased earlier under these rights.

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

Your Dependent must apply for individual purchase and pay the first premium to Us within 31 days after the date his or her coverage under the Group Policy ceases. See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.
The individual policy will be for life insurance only (other than term insurance). No Disability or other benefits will be included. The premium to be paid will be at Our normal rate for your Dependent’s age and risk class on the individual policy’s date of issue.

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

PORTABILITY

Group Policy Provisions

Except as provided below, coverage continued under this provision is subject to all other terms of the Group Policy. With respect to any notice you are required to provide to the Policyholder under other provisions of the Group Policy, such notice must be provided to Us by you while your coverage is continued.

Member Life Insurance

Eligibility

You will be eligible to continue your Member Life Insurance under this Portability feature on the date your employment ends for any reason, other than the termination of the Group Policy. Insurance may be continued under this section if:

- your coverage is not continued under Coverage During Disability provisions described in the booklet on GH 202; or
- you have not received a benefit under Accelerated Benefits provisions described in the booklet on GH 202.

Amount of Continued Member’s Coverage

The maximum amount of Member Life Insurance that may be continued is: An amount equal to the Scheduled Benefit in force on the date your employment ends. You may continue any lesser amount equal to a multiple of your Basic Annual Compensation in force on the date employment ends. You may not at any time increase the amount of coverage continued under this section.

Coverage During Disability as described in this booklet on GH 202-1 will not be included in the continued coverage.

The amount of the continued coverage will be reduced or terminated according to the Scheduled Benefit in force on the date your employment ends.

Termination of Continued Coverage

Your coverage under this section will terminate on the earliest of:

- the premium due date coinciding with or next following the date the Group Policy terminates; or
- the date ending the period for which your last premium is paid for your insurance; or
- the January 1 next following your 70th birthday; or
- the date you become reemployed as a Full-Time Employee of the Policyholder.

Individual Purchase Rights for Members

- Individual Policy

If you qualify and make timely application, you may convert the group coverage by purchasing an individual policy of life insurance under these terms:

- You will not be required to submit Proof of Good Health.
- The policy will be for life insurance only. No disability or other benefits will be included.
- The policy will be on one of the forms, other than term insurance, then issued by Us to persons in the risk class to which you belong on the individual policy’s effective date.
- Premium will be based on your age and Our standard rate for the policy form to be issued.

- **Purchase Qualification**

You will qualify for individual purchase if your coverage which has been continued under this section terminates because the Group Policy terminates.

- **Application/Effective Date**

Notice of the Individual Purchase Right must be given to you by Us before coverage under the Group Policy terminates, or as soon as reasonably possible thereafter.

You must apply for individual purchase and the first premium for the individual policy must be paid to Us within 31 days after the date your coverage terminates under the Group Policy.

Any individual policy issued will then be in force on the 32nd day after such termination date.

- **Individual Policy Amount**

The amount of insurance that you may purchase will be the lesser of:

- $1,000,000; or
- your Member Life Insurance amount in force on the date of termination of the Group Policy, less any Accelerated Benefit payment and Accumulated Interest Charges less the amount for which you become eligible under any group policy within 31 days.

**Dependent Life Insurance**

**Eligibility**

You will be eligible to continue your Dependent Life Insurance under this Portability feature on the date you are eligible to continue your Member Life Insurance.

**Amount of Continued Dependent’s Coverage**

The maximum amount of Dependent Life Insurance you may continue for your Dependents is the amount of Dependent Life Insurance in force for such Dependents on the date your employment ends. You may continue any lesser amount for your Dependent spouse in increments of $10,000. You may not at any time increase the amount of Dependent Life Insurance which has been continued under this section.

In no event will your Dependent’s Scheduled Benefit be more than 50% of your Scheduled Benefit amount.

The amount of your continued Dependent coverage will be reduced or terminated according to the Scheduled Benefit in force on the date your employment ends.

**Termination of Continued Dependent Coverage**

Your coverage under this section for a Dependent will terminate on the earliest of:

- the premium due date coinciding with or next following the date the Group Policy terminates; or
- the date ending the period for which the last premium is paid for your Dependent’s coverage; or
the January 1 next following your spouse’s 70th birthday; or

- the date you become reemployed as a Full-Time Employee of the Policyholder; or

- the date your Member Life Insurance under this section ends; or

- the date your spouse or Dependent Child ceases to be a Dependent as defined in PART I.

**Individual Purchase Rights for Dependents Life Insurance**

- **Individual Policy**

  If your Dependent qualifies and makes timely application, he or she may convert the group coverage by purchasing an individual policy of life insurance under these terms:

  - The Dependent will not be required to submit Proof of Good Health.
  - The policy will be for life insurance only. No disability or other benefits will be included.
  - The policy will be on one of the forms, other than term insurance, then issued by Us to persons in the risk class to which the Dependent belongs on the individual policy’s effective date.
  - Premium will be based on the Dependent’s age and Our standard rate for the policy form to be issued.

- **Purchase Qualification**

  A Dependent will qualify for individual purchase if coverage which has been continued under this section:

  - terminates because the Group Policy terminates; or
  - terminates because you die; or
  - terminates for the Dependent spouse because of divorce or separation from you.

- **Application/Effective Date**

  Notice of the Individual Purchase Right must be given to you by Us before coverage under the Group Policy terminates, or as soon as reasonably possible thereafter.

  A Dependent must apply for individual purchase and the first premium for the individual policy must be paid to Us within 31 days after the date coverage terminates under the Group Policy.

  Any individual policy issued will then be in force on the 32nd day after such termination date.

- **Individual Policy Amount**

  The amount of insurance that a Dependent may purchase may vary:

  - If termination is because the Group Policy terminates as described above, the maximum amount will be the lesser of:
    - $50,000; or
    - the Dependent Life Insurance benefit in force for the Dependent on the date of termination of the Group Policy, less the amount for which the Dependent becomes eligible under any group policy within 31 days.

  - If termination is because you die or because you are divorced or separated as described above, the maximum amount will be the Dependent Life Insurance benefit in force for the Dependent on the date of termination, less any individual policy amount purchased earlier under this section.
Application/Effective Date

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

You must apply and pay the first premium for the continued coverage within 31 days after you become eligible for the Portability option.

Any continued coverage under the Portability option will be in force on the 32nd day after such termination date.

Payment Responsibility; Due Dates; Grace Period

You agree to send all premium due to Our home office in Des Moines, Iowa, while coverage under this section of the Group Policy is in force.

Premiums are due in advance on the first day of each Premium Period. Premiums will be billed directly to you by Us. "Premium Period" means a monthly basis.

Premium payments must be made within 31 days after a due date. A Grace Period of 31 days will be allowed for payment of premium. "Grace Period" means the first 31-day period following a premium due date. Continued coverage will remain in force until the end of the Grace Period, unless the Group Policy has been terminated. You remain liable for submitting premium due for the time coverage remains in force during the Grace Period.

Your continued coverage will terminate, without notice, at the end of a Grace Period if your total premium due has not been received by Us before the end of the Grace Period. Failure by you to pay the premium within the Grace Period will be deemed notice by you to Us to discontinue continued coverage under the Group Policy at the end of the Grace Period.

Administrative Fee

We may charge you a monthly administration fee which will be shown on the Scheduled Benefits Summary.

Our Responsibility to Members

If the Group Policy terminates for any reason, We must:

- notify you of the effective date of the termination; and

- refund all premium contributions received from you for any Premium Period after the effective date of termination.
CLAIM PROCEDURES

Notice of Claim

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

Claim Forms

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

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 90 days for processing claims and up to 60 days for the review of denied claims.

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

A Claimant may request a review of a claim denial by written request to Us within 120 days of receipt of notice of the denial. The Claimant must provide all additional information to Us within one year of receipt of notice of denial. We will notify the Claimant of the final decision and reasons in support of Our decision.

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

Medical Examinations

We may have you or your Dependent whose loss is the basis for claim examined by a Physician as often as is reasonably necessary. We will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 90 days after proof of loss is filed. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

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

NOTE: For additional Claims Procedures information, see GH 198 ERISA Claims.
DEFINITIONS

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

Active Work; Actively at Work mean the active performance of all of your normal job duties at the Policyholder’s usual place or places of business.

Basic Annual Compensation means, on any date, your basic annual (or annual equivalent) wage then in force, as established by the Policyholder. Basic wage does not include commissions, bonuses, tips or overtime pay. Basic wage does include any deferred earnings under a qualified deferred compensation plan and any amount of voluntary earnings reduction under a qualified Section 125 Cafeteria Plan.

Basic Annual Compensation (Partners K-1) means, on any date, your basic annual (or annual equivalent) earnings as established by the Policyholder that:

- with respect to you if you have been a partner for at least two calendar years, was reported as net earnings (loss) from self-employment for the prior two years on Schedule K-1 of Partnership Return of Income, Form 1065, excluding amounts derived from return of capital, interest or dividends; or

- with respect to you if you have been a partner for at least one calendar year, was reported as net earnings (loss) from self-employment on Schedule K-1 of Partnership Return of Income, Form 1065, for the completed calendar years that you have been a partner; or

- with respect to you if you have been a partner for less than one calendar year, your average draw during your period as a partner.

Basic Annual Compensation (Sole Proprietors) means, on any date, your annual net profit that:

- with respect to you if you have been a sole proprietor for at least two calendar years, was reported on Form 1040 Schedule C for the last two calendar years as the gross income less total deductions, minus depreciation and averaged over the last two years; or

- with respect to you if you have been a sole proprietor for less than two calendar years, was reported on Form 1040 Schedule C for the completed calendar years you have been a sole proprietor, as the gross income less total deductions, minus depreciation and averaged over the completed years.

Basic Annual Compensation (Subchapter S Corporations) means, on any date, your basic annual (or annual equivalent) earnings as established by the Policyholder that:

- with respect to you if you have been a shareholder for at least two calendar years, was reported as net earnings (loss) from self-employment for the prior two years on Schedule K-1 of Partnership Return of Income, Form 1065, excluding amounts derived from return of capital, interest or dividends; or

- with respect to you if you have been a shareholder for at least one calendar year, was reported as net earnings (loss) from self-employment on Schedule K-1 of Partnership Return of Income, Form 1065, for the completed calendar years that you have been a shareholder; or

- with respect to you if you have been a shareholder for less than two calendar years, your average draw during your period as a shareholder.

Dependent means:

- Your spouse, if your spouse:
- is not in the Armed Forces of any country; and
- is not insured under the Group Policy as a Member.

- Your Dependent Child (or Children) as defined below.

Dependent will also include any person described above who elects to continue coverage under the Portability provisions described on GH 304.

**Dependent Child; Dependent Children** means:

- Your natural or legally adopted child, if that child:
  - is not married; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is at least 14 days but less than 19 years of age.

- Your stepchild, if that child:
  - meets the requirements above; and
  - receives principal support from you.

- Your foster child, if that child:
  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is approved in writing by Us as a Dependent Child.

- Your child 19 years but less than 23 years of age who otherwise qualifies above, if that child receives principal support from you.

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

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

**Full Time Employee** for any faculty or administrative staff member means any person who is regularly scheduled to work a minimum of a half time appointment, as defined by the Policyholder’s policies and procedures. Full Time Employee also includes any support staff person who is regularly scheduled to work for the Policyholder for at least 1300 hours annually and has an appointment of at least one year Work must be at the Policyholder’s usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

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

- attends school on a full-time basis, as determined by the school’s criteria; and
- is dependent on you for principal support.

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

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

**Member** means any PERSON who is a Full-Time Employee of the Policyholder.

Member will also include any such person who elects to continue coverage under the Portability provisions described on GH 304.

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

- Confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or
- Home Confined. "Home Confined" means that, due to sickness or injury, the person is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical treatment.

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

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

**Physician** means a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

**Policyholder** means THE PRESIDENT AND TRUSTEES OF WILLIAMS COLLEGE DBA WILLIAMS COLLEGE.

**Prior Plan** means the group life insurance coverage of the Policyholder for which the Group Policy is a replacement.

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

**Scheduled Benefits Summary** means the page which is issued as part of your certificate which contains benefits and other information pertaining to your coverage under the Group Policy.

**Skilled Nursing Facility**

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

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.) ; and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

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

**Total Disability; Totally Disabled** means for you, your inability, as determined by Us, due to sickness or injury, to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training or experience.
We, Us, and Our mean Principal Life Insurance Company, Des Moines, Iowa.
STATEMENT OF RIGHTS

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

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**
   
   EIN: 04-2104847  
   PN: 501

2. **Type of Administration:**
   
   Life Insurance Contract.

3. **Plan Administrator:**
   
   THE PRESIDENT AND TRUSTEES OF WILLIAMS COLLEGE DBA WILLIAMS COLLEGE  
   100 SPRING ST  
   WILLIAMSTOWN MA 01267

   See your employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**
   
   THE PRESIDENT AND TRUSTEES OF WILLIAMS COLLEGE, DBA WILLIAMS COLLEGE  
   100 SPRING ST  
   WILLIAMSTOWN MA 01267

5. **Agent for Service of Legal Process:**
   
   THE PRESIDENT AND TRUSTEES OF WILLIAMS COLLEGE, DBA WILLIAMS COLLEGE  
   100 SPRING ST  
   WILLIAMSTOWN MA 01267

   Legal process may also be served upon the plan administrator.

6. **Type of Participants Covered Under the Plan:**
   
   All active full-time employees of THE PRESIDENT AND TRUSTEES OF WILLIAMS COLLEGE DBA WILLIAMS COLLEGE, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 136 A).

7. **Sources and Methods of Contributions to the Plan:**
   
   Employee pays all of employee’s contribution.

   Employee pays all of Dependent’s contribution (if employee elects to enroll Dependents in plan).

8. **Ending Date of Plan’s Fiscal Year:**
   
   June 30

The provisions described below will replace the provisions described in your booklet-certificate.

The Department of Labor has promulgated regulations regarding claims procedure requirements. If your plan of benefits includes Life, STD and/or LTD, the Claims Procedures section of your group booklet-certificate has been changed to comply with the above referenced regulation.

Note: Changes have been made only to reflect the requirements of the ERISA. Any special state requirements relating to payment of claims remain unchanged unless they prevent the application of the ERISA requirements.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to Us within 20 days (3 months for LTD) after the date of loss for which claim is being made. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

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

Proof of Loss

For Life Insurance booklet-certificates

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

For STD and LTD Insurance policies

Claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after you complete your Elimination Period. (For Long Term Disability Insurance, written proof that Disability exists and has been continuous must be sent to Us within six months after you complete your Elimination Period.) Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employment Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the Elimination Period has been completed and the appropriate claim form is received by Us.

Payment, Denial, and Review

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

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

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

For purposes of this section, for Life insurance policies, "claimant" means you, your Dependent or beneficiary. For STD and LTD insurance policies, "claimant" means you.

**Legal Action**

Legal action with respect to a claim may not be started earlier than 90 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Please keep this rider with your booklet-certificate(s). Your booklet-certificate(s) will be updated sometime in the future to incorporate these provisions.

Nothing in this rider will vary, alter, or extend any provision or condition of the group policy(ies) other than as stated in this rider.

**PRINCIPAL LIFE INSURANCE COMPANY**
**DES MOINES, IOWA 50392-0302**
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TRUE NORTH INSURANCE AGENCY INC
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