YOUR BENEFITS

A Plan Designed to Provide Security for Employees of

University of Northern Iowa

Instructional Unit Faculty

Life Insurance
Retirement Protection
Member's Signature
Your insurance has been designed to provide financial help for you when an insured loss occurs. The 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.

Member 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 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.

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 matters 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.

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

PRINCIPAL LIFE
INSURANCE COMPANY
Des Moines, IA 50392-0001
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SUMMARY OF BENEFITS

This section highlights the benefits provided under your plan. 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 your benefits and any limitations or restrictions that might apply.

MEMBER LIFE INSURANCE

If you die, your beneficiary will be paid the Scheduled Benefit in force for you (subject to the exception(s) below). The Scheduled Benefit is based on your class:

<table>
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<th>Class</th>
<th>Scheduled Benefit</th>
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<tr>
<td>All Active Members</td>
<td>*The amount that is equal to your Basic Annual Compensation multiplied by 1 ½ times and rounded to the nearest $1,000, if not already an exact multiple of $1,000. Your Scheduled Benefit amount will not exceed $250,000 or be less than $10,000, subject to the reduction provision below.</td>
</tr>
<tr>
<td>All Retired Members under age 70</td>
<td>**The amount that is equal to one-third of your Scheduled Benefit as an Active Member rounded to the nearest $1,000, if not already an exact multiple of $1,000. Your Scheduled Benefit will be subject to the reduction provision below.</td>
</tr>
<tr>
<td>All Retired Members age 70 or over who retired on or after July 1, 1983 and who have continued their insurance during retirement</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

*Your Insurance will reduce 5% each year on the July 1 coinciding with or next following the attainment of each additional year of age commencing with age 61 (including Members who are age 61 and over on the effective date of your insurance).

**Your Insurance will reduce 5% each year on the July 1 coinciding with or next following the attainment of each additional year of age commencing with age 61 (including Members who are age 61 and over on the effective date of your insurance).
Eligibility

To be eligible for insurance you must be a Member.

Member means any person who is a University Faculty Member with a term, probationary or tenure appointment working at least half time during the academic year and who has attained age 18.

Member will also include any such person who is retired, provided you are age 55 or older, have ten or more years of service with the Policyholder and have been continuously insured prior to retirement.

Member will exclude visiting instructors and/or adjunct professors; students; members of the Armed Forces assigned to the staff of the University, and faculty and staff members holding appointments of a temporary nature.

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 and Eligibility

All statements made by any person insured (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 one year 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 an individual'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.

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

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

If you are required to contribute toward the cost of your insurance, 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.

If you are not required to contribute toward the cost of your insurance, your insurance will
normally be in force on 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 (insurance class or 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 on 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.

A change in your Benefit Payable amount because of a change in age will normally be effective on the July 1 coinciding with or next following the date of the change.

Exception: decreases in Member Life and 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 you cease to be a Member; or
- the date you cease Active Work.

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.

If you cease Active Work because of retirement, your Life Insurance may be continued.

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

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

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

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.
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.

**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 requirements of the Group Policy.
Reinstatement

For Long Term Disability Coverage, a longer reinstatement period may be allowed for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

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. 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 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.

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. See the Policyholder for change request forms. A change in your beneficiary will not be in force until the Policyholder records 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. This continuation is called Coverage During Disability.

To be qualified for Coverage During Disability, you must:

- become Totally Disabled while insured for Member Life Insurance; and
- become Totally Disabled before the June 30th coinciding with or next following the date you attain 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
- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician); 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).

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

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

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

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. You will be considered to be a retired Member on the date you attain age 70 if you are Totally Disabled. Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to age changes and retirement.

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.

**Individual Purchase Rights**

You will have the right to buy an individual life insurance policy without submitting proof of your 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 Member Life Insurance that has terminated less any individual amount purchased earlier under these rights.

- 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) $2,000; or (2) your Member Life Insurance amount.
in force on the date of termination, 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.

You must apply for individual purchase and pay the first premium to Us within 31 days after the date your Member Life Insurance or Coverage During Disability ceases.

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

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

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

Notice of Claim

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

Claim Forms

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

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. 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 reviewing denied claims.

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

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 the person whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

Autopsy

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

Legal action 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 plan 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 the current salary amount appearing opposite your name in the University budget or on your formal letter of appointment. It is determined as of July 1 of each year (or as of the date you became a faculty member is subsequent to July 1) for the 12-month period commencing with such July 1. It is the salary amount for the academic year if payable during 9 months, 10 months or for the fiscal year if payable during 12 months. If you are paid on an hourly rate your Basic Annual Compensation is determined by multiplying your budgeted hourly rate by your normal working hours in the fiscal year. Basic Annual Compensation for the purposes of this insurance, does not include:

- compensation for shift differential, overtime, summer session, correspondence study or other irregular service, or
- compensation in the form of noncash items such as board, room, laundry, or premiums paid by the University for the benefit of any person.

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

**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, 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 University Faculty Member with a term, probationary or tenure appointment working at least half time during the academic year and who has attained age 18.

Member will also include any such person who is retired, provided you are age 55 or older, have ten or more years of service with the Policyholder and have been continuously insured prior to retirement.

Member will exclude visiting instructors and/or adjunct professors; students; members of the Armed Forces assigned to the staff of the University, and faculty and staff members holding appointments of a temporary nature.

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

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

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

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

**Policyholder** means University of Northern Iowa and shall include any affiliate or subsidiary of the Policyholder participating under the Group Policy.

**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.

**Total Disability; Totally Disabled** mean you are not working for wage or profit and, solely and directly because of sickness or injury:

- you are not able to work for the first two years of a disability at your normal occupation. This two-year period will also include the time you meet the definition of Disability under the Policyholder’s Group Long Term Disability Insurance policy, and
- thereafter at any occupation which reasonably fits your background and training.

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


BOOKLET-CERTIFICATE RIDER


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 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

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 the 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.

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 the claimant regarding the extension.

GH 198 ERISA 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 an appeal of a claim denial by written request to Us within 180 days of receipt of the notice of denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify the claimant in writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because We did not receive the requested additional information, We are permitted a 45-day extension for the review. Written notification will be sent to 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 “claimant” means you, your Dependent, or beneficiary.

**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

GH 198 ERISA Claims