LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

GROUP SUPPLEMENTAL LIFE INSURANCE
CERTIFICATE OF COVERAGE

POLICYHOLDER: REED COLLEGE **POLICY NUMBER:** OR 047104

This Certificate is valid only upon receipt of a letter confirming the coverage(s) provided, benefit level(s), name of applicant and effective date which have been approved by LifeMap Assurance Company. This Confirmation Statement must be kept with this Certificate to show verification of coverage. This Certificate is not valid unless accompanied by the Confirmation Statement from LifeMap.

This **Certificate:** (1) is a summary of your insurance under the Group Policy; (2) is not a contract of insurance; (3) is subject to the terms of the Group Policy; and (4) voids and replaces any prior Certificate issued under the Group Policy Number shown above.

The **Policy** is a contract of insurance: (1) between the Policyholder and us; and (2) through which you are insured. Should the terms of this Certificate and the Policy differ, the Policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy.

All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

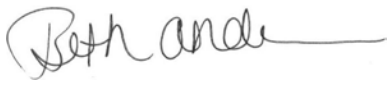
This Certificate includes an Accelerated Benefit. Receipt of this benefit may adversely affect eligibility for Medicaid or other government benefits or entitlements and may be taxable. Assistance should be sought from a personal tax and/or legal advisor before applying for an Accelerated Benefit.

READ THIS CERTIFICATE CAREFULLY: The Coverage Outline on Page P-2 contains information specific to your coverage. The Table of Contents on Page P-3 will help you find specific provisions. The Index of Defined Terms on Page P-4 will tell you where to find the definitions of important terms used in this Certificate.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Assistant Secretary

President



COVERAGE OUTLINE

EMPLOYEE CONTRIBUTION: Supplemental Life Insurance is contributory.

BENEFIT SCHEDULE

SUPPLEMENTAL LIFE INSURANCE FOR EMPLOYEE'S

Increments of $10,000, from a minimum of
$10,000, to a maximum of $500,000

Benefits will be paid according to the amount shown on your Confirmation Statement.

LIFE AND AD&D GUARANTEE ISSUE AMOUNT: $100,000 if applied for within 31 days of initial eligibility based on date of hire. All other amounts, including any increases, and amounts applied for after 31 days of initial eligibility are subject to Evidence of Insurability.

BENEFIT REDUCTIONS: Supplemental Life Benefits reduce to 65% at age 70 and to 50% at age 75.

SUPPLEMENTAL LIFE INSURANCE FOR DEPENDENT SPOUSES

Increments of $5,000, from a minimum of $5,000
to a maximum of $500,000

Benefits will be paid according to the amount shown on your Confirmation Statement.

SUPPLEMENTAL LIFE INSURANCE FOR CHILDREN: Birth to age 26

Increments of $2,000, from a minimum of $2,000
to a maximum of $10,000

Benefits will be paid according to the amount shown on your Confirmation Statement.

SPOUSE SUPPLEMENTAL LIFE GUARANTEE ISSUE AMOUNT: $25,000 if applied for within 31 days of the Employee's initial eligibility based on date of hire, or within 31 days of becoming an eligible Dependent Spouse based on date of marriage. All other amounts, including any increases and amounts applied for after 31 days of becoming eligible, are subject to satisfactory Evidence of Insurability. However, all amounts in force under the prior plan on the day before the Group Policy effective date are Guarantee Issue.

CHILD(REN) SUPPLEMENTAL LIFE GUARANTEE ISSUE AMOUNT: All amounts are Guarantee Issue if applied for within 31 days of the Employee's initial eligibility based on date of hire, or within 31 days of becoming an eligible Dependent. All other amounts, including any increases and amounts applied for after 31 days of eligibility, are subject to satisfactory Evidence of Insurability. However, all amounts in force under the prior plan on the day before the Group Policy effective date are Guarantee Issue.

TABLE OF CONTENTS

INDEX OF DEFINED TERMS

We define some important terms used in this Certificate. Each term and its definition are enclosed in a box for ease of identification. Below is a listing of the page number where each term is defined.

ELIGIBILITY AND EFFECTIVE DATES

This section explains how and when an Employee may enroll under the Policy and when an Employee's insurance will end.

Policy, when capitalized, means the insurance policy issued and delivered to the Policyholder, including any endorsements, amendments and/or riders.

Policyholder means the person, individual firm, trust or other organization named in the Application for the Policy and to whom the Policy has been issued.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Application for the Policy or any Policy amendments.

Application means the document showing the eligible classes, the amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the Policyholder.

Coverage Outline means a summary of the eligible classes, Waiting Periods, amounts of insurance, and other relevant information which applies to the coverage provided by the Policy. It summarizes the plan data shown in the Policyholder's Application. The Coverage Outline forms Page P-2 of this Certificate and Page P-2 of the Group Life and Disability Insurance Certificate.

We, Us and **Our** refer to LifeMap Assurance Company.

You and **Your** refer to the insured Employee.

Employee means a person who is:

1. in Active Employment with the Employer; and
2. eligible for insurance according to the Coverage Outline.

Active Employment means the Employee is:

1. working for the Employer on a regular and active basis for at least the minimum number of hours stated in the Coverage Outline;
2. receiving regular Earnings from the Employer; and
3. employed:
   a. at the Employer's usual place of business; or
   b. at a location to which the Employer's business requires the Employee to travel.

A. ELIGIBILITY

You are eligible for coverage under the Policy if you meet the eligibility requirements stated in the Coverage Outline. Your eligibility date is the **later** of:

1. the effective date of the Policy; or

2. the date specified in the Coverage Outline which follows your completion of the Waiting Period.

Waiting Period means the continuous length of time you must be in Active Employment before becoming eligible for coverage under the Policy. The Waiting Period is shown in the Coverage Outline.

B. EFFECTIVE DATE OF INSURANCE

Subject to Item D. ACTIVELY AT WORK PROVISION and any Evidence of Insurability requirements, you will become insured:

1. **for Noncontributory Insurance** - on your eligibility date;

2. **for Contributory Insurance** - as follows:

   a. if you enroll within 31 days after first becoming eligible, on your eligibility date;
   b. if you enroll more than 31 days after first becoming eligible, on the first day of the billing period following the date we approve Evidence of Insurability.

Noncontributory Insurance means you are not required to pay any part of the premiums.

Contributory Insurance means you must pay a part or all of the premiums. All such payments must be made directly to the Employer.

Evidence of Insurability means a statement or proof of a person's medical history which we will use to determine if the person is approved for insurance. Evidence of Insurability will be at the Employee's expense for late enrollees.

C. WHEN WE MAY REQUIRE EVIDENCE OF INSURABILITY

We will require Evidence of Insurability for all persons applying for insurance, as stated in the Coverage Outline and in any of the following situations:

1. the amount of insurance exceeds the guarantee issue amount shown in the Coverage Outline;

2. for Contributory Insurance - enrollment is made more than 31 days after you first became eligible; or

3. for life insurance, you have previously converted your insurance under the Policy to an individual policy which is in force. If you become eligible again following rehire, no coverage will take effect under the Policy unless satisfactory Evidence of Insurability is submitted to us.

The effective date of coverage may be delayed until we approve the Evidence of Insurability.

D. ACTIVELY AT WORK PROVISION

Coverage will take effect as scheduled only if you are Actively at Work all day on the last regular working day before the scheduled effective date. If you are absent from work due to illness (including pregnancy or complications of pregnancy) or injury, coverage will not become effective until the first day after you complete one full day of Active Work.

However, coverage will take effect on your regular day off, a holiday, or a paid vacation day, if the regularly scheduled effective date falls on that date and you were Actively at Work on the last regular working day before that date.

This Actively at Work requirement also applies to any increase in your coverage.

Actively at Work or **Active Work** means performing the material and substantial duties of your own occupation at the Employer's usual place of business.

E. CHANGES IN INSURANCE

Changes in insurance, due to increases and decreases, and changes in insurance due to attainment of specified ages (see AGE REDUCTIONS) will become effective on the first day of the month following or coinciding with the date of the change (or the 15th day of the month following or coinciding with the date of the change if the effective date of the Policy is the 15th of any month), except that:

1. all increases in insurance are subject to Item D. ACTIVELY AT WORK PROVISION; and

2. insurance which requires Evidence of Insurability will not take effect until we have approved the Evidence of Insurability. In such case, the Policyholder and the Employee will be notified of the effective date of the insurance which required Evidence of Insurability.

F. WHEN INSURANCE ENDS

Your insurance under the Policy will end on the **earliest** of the following dates:

1. the date the Policy terminates;

2. the last day of the period for which you have made any required contribution (Contributory Insurance);

3. the date you enter military service, except for temporary duty of less than 30 days;

4. the date employment terminates;

5. the date you retire, unless coverage for retirees is specifically included in the Policy;

6. the date you cease to be eligible. However, if eligibility ends because of a reduction in the number of hours worked, insurance will be continued with premium payment during the period your ability to work is limited due to illness or injury (unless coverage ends under 1. through 5. above).

   In addition, Life, AD&D and Dependent Life Insurance may be continued with premium payment, unless coverage ends under 1. through 5. above, during the first 90 days of:

   a. a temporary layoff; or
   b. a strike, lockout or other work stoppage caused by a labor dispute between your collective bargaining unit and the Employer.

Life and Dependent Life Insurance may be continued as follows with premium payment during a leave of absence approved by the Employer, in advance and in writing:

1. For a President who completes 5 years of service, coverage continues through the end of the sixth month that immediately follows the month in which the sabbatical leave of absence begins.
2. For a President who completes 10 years of service and has not taken a 6 month sabbatical leave of absence, coverage continues for up to one year following the date the sabbatical leave of absence begins.
3. For Vice Presidents (excluding the VP/Dean of Faculty), coverage continues through the end of the ninth month that immediately follows the month in which the sabbatical leave of absence begins.

4. For VP/Dean of Faculty, coverage continues for up to two years following the date the sabbatical leave of absence begins.
5. For Faculty , coverage continues for up to two years following the date the sabbatical leave of absence begins.
6. For Staff, coverage continues through the end of the ninth month that immediately follows the month in which the sabbatical leave of absence begins.
7. For all Employees on any other leave of absence, coverage continues for up to 1 year following the date the leave of absence begins.

LIFE INSURANCE

We will pay the Life Insurance Proceeds to the Beneficiary when we receive Proof of your death.

Beneficiary or **Beneficiaries** means the person or persons designated to receive the Life Insurance Proceeds.

Beneficiary Designation means the written instrument in which beneficiaries are named or changed. The Beneficiary Designation must be:

1. signed and dated by you; and
2. delivered to the Employer during your lifetime; and
3. in a form acceptable to us.

If the Policy replaces all or part of insurance provided by an earlier group policy through the same Employer, a Beneficiary Designation under the earlier policy may be accepted.

Proceeds means the amount of insurance we will pay as a benefit. This amount is based on the class of insurance for which the person is eligible according to the Coverage Outline.

Earnings means wages or salary received from the Employer but **does not** include:

1. overtime pay;
2. bonuses; or
3. any other form of extra compensation, except commissions.

Commissions will be averaged over the 12 month period just prior to the date of loss or for the period of employment if less than 12 months.

FACILITY OF PAYMENT

The following paragraphs describe to whom we will pay the Proceeds when you die. Our liability for the payment ends if we make it in good faith.

A. PAYMENT TO BENEFICIARIES

We will pay the Proceeds to the designated Beneficiary or Beneficiaries listed on your enrollment form. If one or more Beneficiaries die before you, the deceased Beneficiaries and their estates have no rights to the Proceeds. Two or more surviving Beneficiaries will share equally, unless otherwise specified.

B. WHEN THERE IS NO SURVIVING BENEFICIARY

If there is no designated Beneficiary, or if the designated Beneficiary does not survive you, we will pay the Proceeds in equal shares to your surviving relatives of the highest rank of the following:

1. spouse;
2. children;
3. parents; or
4. your estate.

Children, for the purposes of this Facility of Payment provision only, means biological children and adopted children.

C. IF THE BENEFICIARY IS A MINOR OR INCOMPETENT

If a Beneficiary is a minor or not competent, we have the right to pay up to $500 to the person or institution who appears to us to have assumed the Beneficiary's custody and principal support. We will take this action until or unless a formal complaint is made by a legal representative of the Beneficiary.

Our liability for the above payment ends if we make it in good faith. We will pay remaining benefits upon Proof acceptable to us of guardianship or conservatorship to the legal estate of the minor child or incompetent Beneficiary.

D. ADDITIONAL PAYMENT OF PROCEEDS

We may pay up to $500 of the Proceeds, according to law, to any person who appears to us to have incurred costs from your last illness, death, or funeral.

E. SUPPLEMENTAL LIFE INSURANCE SUICIDE EXCLUSION

Supplemental Life Insurance benefits will not be paid for death resulting from:

1. suicide;
2. intentionally self-inflicted injury; or
3. any attempt to injure oneself, whether sane or insane,

during the first two years of coverage.

In the event you:

1. apply for; and
2. have approved by us,

an additional amount of Supplemental Life Insurance, the above exclusion will apply only:

1. to the increase in coverage; and
2. for the first two years after the effective date of the increase in coverage.

SETTLEMENT OPTIONS

We will pay the Proceeds in a lump sum to the designated Beneficiary or Beneficiaries unless another settlement option has been selected. Following are the other settlement options available.

A. MONTHLY PAYMENTS

Proceeds may be paid to each Beneficiary on a monthly basis for a fixed term of years if:

1. a written election is made by you; or
2. we receive a written request from each Beneficiary who is to receive Proceeds; and
3. we agree.

Each such monthly payment must be at least $100.

The following table describes how monthly payments will be calculated.

TABLE OF MONTHLY PAYMENTS PER $1,000 OF PROCEEDS

Years Payable	Monthly Payment
1	$84.28
2	$42.66
3	$28.79
4	$21.86
5	$17.70
10	$ 9.39
15	$ 6.64
20	$ 5.27

The above payments are based on 2.5% interest, compounded annually. We may also pay an additional interest that we may declare from year to year.

The first payment will be paid:

1. on the date Proceeds would have been paid in one sum; or

2. on the date the Beneficiary requests.

If all Beneficiaries receiving monthly payments die, we will pay the unpaid Proceeds plus earned interest in one sum to the estate of the last surviving Beneficiary.

B. OTHER SETTLEMENT OPTIONS

Other settlement options may be arranged if you and we agree. We will furnish data on these other options upon request.

EXTENSION OF LIFE INSURANCE DURING TOTAL DISABILITY

This provision only applies to Employee Supplemental Life Insurance.

Subject to the conditions which follow, we will continue your Life Insurance if we receive Proof of your Total Disability which began while this insurance was in force.

Total Disability or **Totally Disabled** means that as the result of illness or injury you are unable to perform the material duties of **any** occupation for which you are or become reasonably suited by education, training or experience.

Premiums for you must be paid to us during the first six months of your continuous Total Disability. If you submit Proof of Total Disability acceptable to us, Life Insurance will be continued without further payment of premium:

1. for the period of continuous Total Disability beyond six months; and

2. for as long as the required Proof of continuous Total Disability is given to us, subject to Item D. WHEN EXTENDED LIFE INSURANCE ENDS.

We will refund up to 12 months of premiums that were paid for Life Insurance after the date you became Totally Disabled.

A. QUALIFYING FOR EXTENDED INSURANCE

To qualify for extended insurance, you must:

1. be Totally Disabled due to injury or illness;

2. first become Totally Disabled while insured for Life Insurance under this Policy;

3. have been Totally Disabled for at least six consecutive months;

4. be under age 60 on the date Total Disability began;

5. give us written Proof of continuous Total Disability within 12 months after the date the Total Disability began; and

6. give us written Proof of continuous Total Disability during the last three months of each subsequent 12 month term after the first.

If Proof of continuous Total Disability cannot be given to us within these times:

1. it must be given as soon as is reasonably possible; and

2. it must be given within three months after the time it is otherwise required.

We have the right to require that you undergo an exam by a Physician of our choice or approved by us. This exam will be done at our expense. We will not require an exam more than once a year after Total Disability has continued for two years.

NOTE: If you become Totally Disabled on or after your 60th birthday, but otherwise meet the above conditions for extended insurance, your Employer may continue to pay premium for you, subject to Item D. WHEN EXTENDED LIFE INSURANCE ENDS. If the Employer elects this option for any qualified Employee, it must be elected for all qualified Employees. Coverage extended in this manner ends on the date the Policy terminates.

If you do not meet the above conditions for extended insurance and your coverage ends under the Policy, you may convert to an individual life policy under the terms shown in CONVERSION.

B. AMOUNT OF EXTENDED INSURANCE

The amount of insurance extended or paid will be the amount for which you were covered on the last day of Active Work, subject to any reduction or termination provisions of the Policy.

C. IF THE INSURED DIES

If you die prior to the date satisfactory Proof of Total Disability is furnished, we will pay the amount that would otherwise have been continued, if:

1. the Total Disability began while you were covered under the Policy; and
2. your death occurred within one year after the date the Total Disability began; and
3. we are given Proof of continuous Total Disability within one year after the date you died; and
4. we are given Proof of death.

D. WHEN EXTENDED LIFE INSURANCE ENDS

Extended Life Insurance will end on the earliest date you:

1. are no longer Totally Disabled;
2. fail to give us the required Proof of continuous disability;
3. refuse to undergo a medical exam at our request;
4. reach age 65; or
5. convert to an individual policy.

E. CONVERSION RIGHTS

If this extended Life Insurance benefit ends, or is denied, you become entitled to the conversion rights of the Policy as if eligibility ended on the date this benefit ended or was denied. However, if you become insured again under the Policy within 31 days after extended benefits ended, conversion rights will be denied.

ACCELERATED BENEFIT FOR TERMINAL ILLNESS

This provision applies to Employee and Dependent Supplemental Life Insurance.

If you are diagnosed by a Physician as Terminally Ill while insured for Life Insurance under the Policy, you may request payment of an Accelerated Benefit.

Accelerated Benefit means the amount of Life Insurance that may be paid in advance of your death if you are Terminally Ill. The amount of the Accelerated Benefit will be determined as shown in Item A. BENEFIT AMOUNT AND BENEFIT COST.

Terminally Ill or **Terminal Illness** means that you are diagnosed as having a medical condition that causes your life expectancy to be six months or less. Satisfactory Proof of such limited life expectancy must be submitted to us. Proof shall include, but is not limited to, clinical, radiological and laboratory evidence.

We may require, at our expense, an exam by a Physician of our choice.

Physician means a person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. is legally qualified as a medical practitioner and is required to be recognized under the Policy for insurance purposes according to the insurance statutes/regulations of the governing jurisdiction; and
3. is not the Employee or a relative of the Employee.

A. BENEFIT AMOUNT AND BENEFIT COST

If you voluntarily request payment of an Accelerated Benefit and provide satisfactory Proof, we will pay the benefit to you. You may select the Accelerated Benefit amount, except that the amount may not exceed the **lesser** of:

1. 80% of the Life Insurance in force on your life; or

2. $250,000.

There is no cost for the Accelerated Benefit unless it is exercised. If exercised, the cost will be:

1. an administrative fee of $200; **plus**

2. the interest, in advance, on the Accelerated Benefit for six months.

In no event will the interest rate be higher than the **greater** of:

1. the current yield on 90-day Treasury bills; or

2. the current maximum statutory adjustable policy loan interest rate.

The following formula will be used to calculate the interest charged:

Let A = amount of Accelerated Benefit you requested
i = annual interest rate charged
I = amount of interest charged

$$I = A - \frac{A}{1 + (i/2)}$$

The cost of the benefit as defined above will be deducted from the Accelerated Benefit Proceeds.

The Accelerated Benefit will be paid in one lump sum. Only one Accelerated Benefit may be paid during your lifetime.

B. CONDITIONS

Payment of an Accelerated Benefit is subject to the following conditions:

1. The written consent of any assignee or irrevocable beneficiary must be given to us.

2. The Accelerated Benefit is available on a voluntary basis only, therefore:

   a. if you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
   b. if you are required by a government agency to use this option in order to apply for, obtain or keep a government benefit or entitlement;

   you are not eligible for this benefit.

3. In the event you die after a request is made, but before the Accelerated Benefit is paid:

   a. the Accelerated Benefit is not payable; and
   b. the Life Insurance Proceeds of the Policy will be paid to the Beneficiary as if no request had been made.

4. The Accelerated Benefit is not available to retirees.

C. INDEPENDENT MEDICAL OPINION

If you and we do not agree on the diagnosis of Terminal Illness, either may request, in writing, the opinion of an independent Physician as follows:

1. Each party will select a Physician.

2. Both Physicians will:

   a. examine you and all medical records; and
   b. submit an opinion.

3. If the two Physicians do not agree, they will choose a third disinterested Physician acceptable to both.

4. The third Physician will:

   a. examine you and the medical records; and
   b. provide an independent third opinion.

5. If the opinion of the third Physician is in your favor, we will:

    a. accept the decision as binding; and
    b. pay the expenses of the Physicians involved.

6. If the opinion is in our favor:

    a. we will pay the expenses of our Physician and the third Physician; and
    b. you will pay the expenses of your Physician.

7. A decision by the third Physician in our favor is not binding on you; you may take further action.

D. EFFECT ON LIFE AMOUNT

The amount of your Life Insurance after payment of an Accelerated Benefit will be the amount of Life Insurance in force as if no Accelerated Benefit had been paid; **less:**

1. the cost of this benefit (as figured in Item A. BENEFIT AMOUNT AND BENEFIT COST); and

2. the Accelerated Benefit paid to you.

E. WAIVER OF PREMIUM

At the time the Accelerated Benefit is paid, we will waive the Life Insurance premium for the amount of Life Insurance which remains in force.

CONVERSION

Subject to the conditions which follow, any person insured under the Policy may convert all or part of this coverage to an individual life policy without Evidence of Insurability.

A. ELIGIBILITY FOR CONVERSION

An insured person will be eligible to obtain an individual life insurance policy during the conversion period if his or her coverage, or any portion of it, ends under the Policy due to:

1. termination of employment;

2. termination of membership in an eligible class;

3. ceasing to be eligible according to the eligibility provisions of the Policy;

4. retirement; or

5. termination or reduction of benefit due to reaching a specified age as shown in the Coverage Outline.

B. TIME LIMIT FOR CONVERSION

We will issue an individual life policy only if the insured person gives us a written request to convert within 31 days of the date his or her coverage ends under the Policy.

The premiums for the first term of coverage for the individual policy must be paid before the policy will be issued. The new policy will take effect at the end of the 31 day conversion period.

C. CONVERSION POLICY BENEFITS

The conversion policy may be on any individual plan of life insurance offered by us, except term insurance. The new policy will not include disability or any other supplemental benefits. Premium rates for the new policy will be based on:

1. the person's age at the date of issue; and

2. the premium rates then in use by us.

The face amount of the new policy may not exceed the amount of group life insurance in force on the last day of coverage, but must be at least $1,000.

D. CONVERSION WHEN THE POLICY TERMINATES

If the Policy terminates or if the Policy is amended so as to reduce or terminate insurance, the person's conversion rights are limited as follows:

1. Conversion is available only if the person was covered under the Policy for five years prior to the date of termination of insurance; and

2. The amount the person may convert is limited to the lesser of:

   a. the amount of insurance which ended under the Policy, less any other group life insurance through the same Employer for which the person becomes eligible during the 31 day conversion period; or
   b. $10,000.

The face amount of the new policy must be at least $1,000.

E. IF THE INSURED PERSON DIES

If the insured person dies during the 31 day conversion period, we will pay a life benefit under the Policy. The Proceeds payable will be the maximum amount available for conversion, whether or not application for conversion was made.

Any individual policy issued in accordance with this conversion provision must be surrendered without a claim and any premiums paid for it will be refunded.

F. PROTECTING THE RIGHT TO EXTENDED INSURANCE

Conversion to an individual policy will not void any right under extended insurance if all of the conditions of that provision are met within the time required. If insurance is extended, any individual policy issued in accordance with this conversion provision must be surrendered without a claim and any premiums paid for it will be refunded.

DEPENDENT LIFE INSURANCE

We will pay the Proceeds due under this Dependent Life Insurance section to you when we receive Proof of an insured Dependent's death.

Dependent means your Spouse or Child who is not in full time military service.

Spouse means your legal husband or wife as defined by your state of residence. If a husband and wife are both insured under this Policy as Employees, then each may be insured as a Spouse under the other Employee's Dependent Life Insurance.

Child means your unmarried child from live birth up to the limiting age shown in the Coverage Outline and includes:

1. your biological child, adopted child or step-child;
2. a child placed in your home pending adoption by you; or
3. a child related to you by blood or marriage for whom you are the legal guardian.

Such child, other than a biological child under age 26, must live with you, unless:

1. the child is enrolled as a full time student at an accredited school; or
2. you are legally required to contribute to his or her support.

A disabled child can remain insured past the limiting age shown in the Coverage Outline. Such child must be:

1. unmarried;
2. incapable of self-support because of a physical handicap or developmental disability; and
3. chiefly dependent on you for support or maintenance; or
4. institutionalized due to physical handicap or developmental disability;

and the disabling condition must have existed before the child reached the limiting age shown in the Coverage Outline.

To obtain continued coverage, you must apply to us and receive approval from us before the disabled child attains the limiting age. We may require subsequent Proof of continuing disability at reasonable intervals.

A. DEPENDENT'S ELIGIBILITY

A dependent becomes eligible for coverage on the later of the following dates:

1. the date you become eligible; or

2. the date the person becomes a Dependent.

B. DEPENDENT'S EFFECTIVE DATE

Subject to Item C. DEFERRED EFFECTIVE DATE and any Evidence of Insurability requirements, an eligible Dependent becomes insured:

1. for **Noncontributory Insurance -** on the later of the following dates:
   a. the date your insurance takes effect; or
   b. the date you first acquire a Dependent.

2. for **Contributory Insurance -** as follows:

    a. for Dependents enrolling within 31 days after first becoming eligible, on the date the Dependent becomes eligible; or
    b. for Dependents enrolling more than 31 days after first becoming eligible, on the first day of the billing period following the date we approve Evidence of Insurability for such dependent.

C. DEFERRED EFFECTIVE DATE

If, on the date a Dependent would otherwise become insured or receive an increase in coverage, the Dependent is confined to a hospital, skilled nursing facility or similar institution due to an illness or injury, that Dependent's effective date will be deferred until the Dependent is no longer confined.

D. BENEFIT AMOUNT

We will pay Proceeds based on the amount of insurance shown in the Coverage Outline for:

1. the Dependent's age at the time of his or her death; and

2. according to your class on the date of the Dependent's death.

E. WHEN INSURANCE ENDS

A Dependent's insurance under the Policy will end on the **earliest** of the following dates:

1. the date the person ceases to be an eligible Dependent;

2. for the Spouse, the date divorce is final;

3. the last day of the period for which you have made any required contribution (Contributory Insurance);

4. the date your coverage under the Policy ends;

5. the date all Dependent coverage ceases under the Policy; or

6. the date you are eligible for extended life insurance.

F. CONVERSION

If an insured Dependent no longer qualifies for life insurance under the Policy, the Dependent may be able to exercise the right to a conversion policy. Refer to the CONVERSION provision in LIFE INSURANCE for the conditions under which conversion may be available.

G. SUPPLEMENTAL LIFE INSURANCE SUICIDE EXCLUSION

Supplemental Life Insurance benefits will not be paid for death resulting from:

1. suicide;

2. intentionally self-inflicted injury; or

3. any attempt to injure oneself, whether sane or insane,

during the first two years of coverage.

In the event the Insured Spouse or Child:

1. applies for; and
2. has approved by us,

an additional amount of Supplemental Life Insurance, the above exclusion will apply only:

1. to the increase in coverage; and
2. for the first two years after the effective date of the increase in coverage.

CLAIMS

This section explains some of the terms and conditions relating to payment of claims.

A. CLAIM FORMS

We will furnish the claim forms for filing Proof of Loss within 15 days after they are requested. If we do not do so, the claimant may comply with the Proof of Loss requirements of the Policy by submitting:

1. written Proof showing the occurrence, nature and extent of the loss for which claim is made;

2. the Proof within the time fixed in Item B. PROOF OF LOSS.

Proof or **Proof of Loss** means a properly completed claim form; **plus:**

1. for **Life Insurance -** a certified death certificate or a death decreed by court order;
2. for **Accidental Death -** in addition to the certified death certificate:
   a. coroner's report;
   b. investigating agency's report;
   c. Employer's Workers' Compensation report of claim, if applicable; and
   d. news accounts, if available;
3. for **Accidental Dismemberment -**
   a. medical records;
   b. police records;
   c. Employer's Worker's Compensation report of claim, if applicable; and
   d. news accounts, if available;
4. for **Disability** - written proof of disability acceptable to us.

B. PROOF OF LOSS

1. Written Proof of Loss must be furnished to us at our Home Office within 90 days after the date of the loss.

2. Failure to furnish Proof will not invalidate nor reduce any claim if it is not reasonably possible to give Proof within 90 days, provided the Proof is furnished as soon as reasonably possible.

3. In no event, except in the absence of legal capacity of the claimant, may Proof be given later than one year from the time Proof is otherwise required.

4. Proof of continuing disability must be furnished within 90 days of the date such Proof is requested.

C. PHYSICAL EXAM AND AUTOPSY

We have the right and opportunity to have a person whose injury or illness is the basis of a claim examined by a Physician of our choice at our expense. This right may be used as often as reasonably required while the claim is pending and, in the case of death, includes an autopsy, where it is not forbidden by law.

D. PAYMENT OF CLAIMS

We will pay the Proceeds for insured losses as soon as we receive satisfactory Proof of Loss. Short Term Disability Benefits will be paid at the end of each week you qualify for benefits. Short Term Disability Benefits remaining unpaid at your death will be paid to your estate.

E. REVIEW PROCEDURE

A claimant has the right to a review of any denial by us of all or any part of a claim. To obtain a review, a written request for review should be sent to us at our Home Office within 60 days after the claimant receives notice of denial. No special form is required.

The claimant may submit written comments and provide additional documentation in support of the claim, and may review any non-privileged information relating to the request for review.

We will review the claim promptly after receiving the request. We will send the claimant written notice of our decision within 60 days after the request for review is received, or within 120 days if special circumstances require an extension. The notice will include the reasons for the decision and will refer to the specific provisions of the Policy on which the decision is based.

Another person may be authorized to act for the claimant under this review procedure.

F. LEGAL ACTIONS

A claimant or the claimant's authorized representative may not start any legal action:

1. until 60 days after Proof of Loss has been given; or

2. more than three years after the time Proof of Loss is required to be given.

G. ALLOCATION OF AUTHORITY

In making any benefits determination under the Policy, we shall have the full and complete authority to determine:

1. a person's eligibility for insurance;

2. a person's entitlement for benefits;

3. the amount of benefits payable; and

4. the adequacy and amount of information we may reasonably require to make a determination of 1., 2., or 3. above; and

to construe the terms of the Policy, including but not limited to, the authority to administer claims, to interpret the Policy provisions, and to render a decision in case of request for review.

H. INCONTESTABILITY

In the absence of fraud, any statement by you or your Dependent to obtain coverage under the Policy will be a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage unless:

1. coverage would not have been approved except for the misrepresentation;

2. the misrepresentation is contained in a written instrument signed by you or your Dependent; and

3. a copy of the written instrument containing the misrepresentation has been given to you, the Dependent or the Beneficiary.

After coverage has been in effect for two years during the lifetime of the person, no misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

I. ASSIGNMENT

The Policy may not be assigned, but you may assign your rights under the Policy. We are not liable for the assignment's validity or sufficiency. We are not bound by an assignment until we receive it.

GENERAL POLICY PROVISIONS

A. MISSTATEMENT OF AGE

If a person's age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon the person's age, the benefit amount will be the amount the person would have been entitled to if his or her correct age were known.

NOTE: A refund will not be made for a period more than 12 months before the date we are advised of the error.

Clerical error or omission will not:

1. cause an ineligible employee to become insured;
2. invalidate insurance otherwise validly in force; or
3. continue insurance validly terminated.

B. POLICY CHANGES

The Policy may be changed in whole or in part. No change will be valid unless approved by one of our officers or the policy registrar. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or waive any part of it.

C. AGENCY

For all purposes under the Policy the Policyholder acts on its own behalf or as agent of the Employee. Under no circumstances will the Policyholder be deemed our agent without a written authorization.

D. CERTIFICATES

The Employer is responsible for giving to you a complete copy of the Certificate for your applicable class within 31 days after receipt of the Certificates from us.

Certificate means a document prepared by us which sets forth:

1. the benefits to which the insured Employee is entitled;
2. the method by which we determine to whom benefits are payable; and
3. the conditions, limitations, exclusions and requirements that apply.

E. WORKERS' COMPENSATION

This insurance is not in lieu of Workers' Compensation; it does not affect any requirement for Workers' Compensation coverage.

PORTABILITY ENDORSEMENT

This Endorsement is attached to and made a part of the Policy or Certificate.

NOTE: This endorsement applies only to the Supplemental Life Insurance under this Policy. When an Insured elects Portability, the terms and conditions of the Policy will continue to apply, except as specifically stated in this endorsement.

An employee and/or spouse may elect to continue Supplemental Life Insurance under the group Policy if coverage ends because:

1. the employee terminates employment with the Policyholder or an employer insured under the Policyholder; or
2. the employee ceases to be in an eligible class; or
3. the employee retires; or
4. the employee is working less than the minimum number of hours per week required to maintain coverage.
5. for Spouse and Child(ren) coverage:
   a) the employee ports coverage; or
   b) the employee dies; or*
   c) the employee is eligible for extended life insurance.*

   *However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

ELIGIBILITY

To qualify for Portability, an employee and/or spouse must:

1. be insured for Supplemental Life Insurance under the Policy immediately before electing Portability; and
2. submit a written request for Portability coverage with payment of the first premium within 31 days of the date coverage ends under the group Policy.

Portability is not available to an employee who is eligible for Extended Life Insurance under the Policy. Portability is not available to any employee and/or spouse who is opting for coverage under a Conversion Policy.

BENEFIT

The maximum amount of insurance that may be continued is the amount of Supplemental Life Insurance in force on the day coverage would otherwise have ended under the Policy. However, the maximum amount that can be ported in combination with any Basic Life Insurance is limited to $500,000. An employee or spouse may choose to continue a lesser amount of insurance in multiples of $10,000. Supplemental Dependent Life is included under Portability coverage. Employees may increase their amount of portable Supplemental Life Insurance at any time by submitting satisfactory Evidence of Insurability.

LIMITATIONS

The provision in the Policy entitled EXTENSION OF LIFE INSURANCE DURING TOTAL DISABILITY is not available for any disability that begins after coverage under Portability becomes effective. Once Portability becomes effective, the ACCELERATED BENEFIT FOR TERMINAL ILLNESS is not available.

PREMIUM

The premium for Portability coverage will be the same as the premium paid for Supplemental Life Insurance under the group Policy, except that a processing fee will be added to each bill. Premium may be paid on a quarterly, semi-annual or annual basis.

TERMINATION OF PORTABILITY COVERAGE

Portability coverage will terminate on the earliest of the following dates:

1. the date the group Policy terminates;
2. the date the employee's coverage becomes effective under the same group Policy after returning to work for the Policyholder or an employer insured under the Policyholder;
3. the day after the last period for which premiums were paid;
4. for a dependent child, the date the child ceases to qualify under the terms "Child(ren)" or "Dependent" as defined in the group Policy.

An Employee and/or Spouse who ceases to qualify for Portability Insurance may purchase a Conversion Policy as stated in the group Policy.

LIFEMAP ASSURANCE COMPANY

President

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

This Endorsement is effective April 1, 2008.

STATE CERTIFIED DOMESTIC PARTNER ENDORSEMENT

The Policy or Certificate to which this endorsement is attached is amended as follows:

Definition Change. The Definition of "Spouse" shall include state certified domestic partners.

Eligibility for Children of State Certified Domestic Partners. If your Policy provides coverage for Dependents, the children of state certified domestic partners shall be eligible for coverage under the same terms and conditions as children of a Spouse.

Termination of Domestic Partnership. In the event the domestic partnership terminates, the same termination rules that apply for divorce shall apply for termination of the domestic partnership.

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.

LIFEMAP ASSURANCE COMPANY

Assistant Secretary

President

RLH OR GRP SCDP 02/08

CONVERSION ENDORSEMENT

This endorsement is attached to and replaces the **CONVERSION** provision of the Group Policy and Certificate of Coverage.

CONVERSION

This provision does not apply to Accidental Death and Dismemberment Insurance.

Subject to the conditions which follow, any person insured under this Policy may convert all or part of this coverage to an individual life policy issued by Texas Life Insurance Company (herein called Texas Life) without Evidence of Insurability. Time served under this Policy will apply to the incontestability and suicide exclusion provisions of the conversion policy issued by Texas Life.

A. ELIGIBILITY FOR CONVERSION

An insured person will be eligible to obtain an individual life insurance policy during the conversion period if his or her coverage, or any portion of it, ends under this Policy due to:

1. termination of employment;
2. termination of membership in an eligible class;
3. ceasing to be eligible according to the eligibility provisions of this Policy;
4. retirement; or
5. termination or reduction of benefit due to reaching a specified age as shown in the Coverage Outline.

B. TIME LIMIT FOR CONVERSION

An individual life insurance policy will be issued only if the insured person gives Texas Life a written request to convert within 31 days of the date his or her coverage ends under this Policy.

The premiums for the first term of coverage for the individual policy must be paid before the policy will be issued. The conversion policy will take effect at the end of the 31 day conversion period.

C. CONVERSION POLICY BENEFITS

The conversion policy will be on an individual plan of life insurance offered by Texas Life, except term insurance, and will not include any disability benefits. Premium rates for the conversion policy will be based on:

1. the person's age at the date of issue of the whole life policy; and
2. the premium rates then in use by Texas Life.

The face amount of the conversion policy must be at least $1,000, but may not exceed the lesser of:

1. The amount of group life insurance in force under this Policy on the last day of coverage; or

2. $150,000.

D. CONVERSION WHEN THIS POLICY TERMINATES

If this Policy terminates or is amended so as to reduce or terminate insurance, the person's conversion rights are limited as follows:

1. Conversion is available only if the person was covered under this Policy for five years prior to the date of termination of insurance; and

2. The amount the person may convert is limited to the lesser of:

   a. the amount of insurance which ended under this Policy, less any other group life insurance through the same Employer for which the person becomes eligible during the 31 day conversion period; or

   b. $10,000.

The face amount of the conversion policy must be at least $1,000.

E. IF THE INSURED PERSON DIES

If the insured person dies during the 31 day conversion period, we will pay a life benefit under this Policy. The Proceeds payable will be the maximum amount available for conversion, whether or not application for conversion was made.

Any individual policy issued in accordance with this conversion provision must be surrendered without a claim and any premiums paid for it will be refunded.

F. PROTECTING THE RIGHT TO EXTENDED INSURANCE

Conversion to an individual policy will not void any right under extended insurance if all of the conditions of that provision are met within the time required. If insurance is extended, any individual policy issued in accordance with this conversion provision must be surrendered without a claim and any premiums paid for it will be refunded.

ERISA

SUMMARY PLAN DESCRIPTION

Name of Plan:
Reed College

Policy Number:
OR 047104

Identification Number:
23221 001

Participants Included:
Refer to Employer under each plan.

Name and Address of Employer:
Reed College
3203 SE Woodstock Blvd
Portland, Oregon
97202

Contributions:
Refer to Employee Contributions under each plan.

Plan Identification Number:
a. Employer IRS Identification #: 93-0386908
b. Plan #: 501

Plan Year Ends:
June 30

Plan Administrator, Name, Address, and Telephone Number:
Reed College
3203 SE Woodstock Blvd
Portland, Oregon
97202
(503) 777-7704

Agent for Service of Legal Process on the Plan:
Reed College
3203 SE Woodstock Blvd
Portland, Oregon
97202

TYPE OF ADMINISTRATION
Insurer Administration

AMENDING THE EMPLOYER'S ERISA PLAN

The Employer's ERISA plan may be changed in whole or in part by the Employer's company. Such changes must be in writing and endorsed on or attached to the ERISA plan.

AMENDING RLH'S SUMMARY OF BENEFITS

The Summary of Benefits may be changed in whole or in part. The Employer can request a Summary of Benefits change. Only an officer or registrar of RLH can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

NOTE: If you end active employment, see your supervisor to determine what arrangements, if any, may be made to continue your coverage beyond the date you end active employment.

WHO CAN CANCEL THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS?

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by RLH; or
- by the Policyholder.

RLH may cancel or offer to modify the Summary of Benefits or a plan if:

- for a plan with less than 200 eligible employees, the number of employees insured is less than 15 lives or 25% of those eligible, whichever is greater; or
- for a plan with 200 or more eligible employees, the number of employees insured is less than 50 lives or 15% of those eligible, whichever is greater; or
- the Employer does not promptly provide RLH with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- the Employer fails to pay any premium within the 31 day grace period.

If RLH cancels the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date.

If the premium is not paid during the grace period, the Summary of Benefits or a plan will terminate automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay RLH all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to RLH at least 31 days prior to the cancellation date. When both the Employer and RLH agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If RLH or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

WHAT ARE YOUR RIGHTS UNDER ERISA?

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:

– examine, without charge, at the Plan Administrator's office and at other specified locations, all plan documents including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
– obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies; and
– 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 the summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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. 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 frivolous.

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

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

WHAT IF YOUR CLAIM IS DENIED?

In the event that your claim is denied, either in full or in part, RLH will notify you in writing within 90 days after your claim form was filed. Under special circumstances, RLH is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from RLH indicating the reason for the delay and the date you may expect a final decision. RLH notice of denial shall include:

– the specific reason or reasons for denial with reference to those Summary of Benefits' provisions on which the deinal is based;
– a description of any additional material or information necessary to complete the claim and of why that material or information is necessary; and
– the steps to be taken if you or your beneficiary wish to have the decision reviewed.

Please note that if RLH does not respond to your claim within the time limits set forth above, you should automatically assume that your claim has been denied and you should begin the appeal process at that time.

WHAT DO YOU DO TO APPEAL?

If you or your authorized representative appeal a denied claim, it must be submitted within 60 days after you receive RLH's notice of denial. You have the right to:

– submit a request for review, in writing, to RLH;
– review pertinent documents; and
– submit issues and comments in writing to RLH.

RLH will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for prcessing, you will be notified of the reasons for the extension, and a decision shall be made not later than 120 days following receipt of the request for review. The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those summary of Benefits' provisions upon which the final decision is based.