

**CALIFORNIA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER**

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting well managed and financially stable insurers.

The California Life and Health Insurance Guaranty Association may not provide coverage for this insurance. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your insurance or any portion of it that is not guaranteed by the Insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.

If you have additional questions, you should first contact your insurer or agent and then may contact:

**California Life and Health
Insurance Guaranty Association
P.O. Box 16860
Beverly Hills, CA 90209**

OR

**Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013**

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

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- their insurer was not authorized to do business in this state when it issued the policy or contract;
- their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- they are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state.

The Association also does not provide coverage for:

- unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- employer and association plans to the extent they are self-funded or uninsured;
- synthetic guaranteed interest contracts;
- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance unless an assumption certificate was issued;
- interest rate yields that exceed an average rate; and
- any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

Life and Annuity Benefits

80% of what the life insurance company would owe under a life policy or annuity contract up to

- \$100,000 in cash surrender values;
- \$100,000 in present value of annuities; or
- \$250,000 in life insurance death benefits.

A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

Health Benefits

A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the act applies.

NOTICE

Benefits paid under the Accelerated Benefits provision will reduce the Death Benefit payable for life insurance.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Employee or the Employee's beneficiary may incur a tax obligation. As with all tax matters, an Employee should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

TL-004788

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER: TRUSTEE OF THE GROUP INSURANCE
TRUST FOR EMPLOYERS IN THE
SERVICES INDUSTRY

SUBSCRIBER: The Scripps Research Institute

POLICY NUMBER: FLI-960054

POLICY EFFECTIVE DATE: January 1, 2006

POLICY ANNIVERSARY DATE: January 1

This Policy describes the terms and conditions of coverage. It is issued in Delaware and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.

Susan L. Cooper

Susan L. Cooper, Secretary

Karen S. Rohan

Karen S. Rohan, President

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SCHEDULE OF BENEFITS

Premium Due Date

Premiums are due in arrears on the date coinciding with the day of the Policy Anniversary Date or the last day of the month, if earlier.

Classes of Eligible Employees

Class 1 All active, Full-time and Part-time Employees of the Employer regularly working a minimum of 20 hours per week.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

For Employees hired on or
before the Policy Effective Date: No Waiting Period.

For Employees hired after
the Policy Effective Date: No Waiting Period.

LIFE INSURANCE BENEFITS

Employee Benefits

Benefit Amount	\$10,000 or an amount equal to 1, 2 or 3 times Annual Compensation rounded to the nearest \$1,000, if not already a multiple thereof.
Minimum Benefit:	\$10,000
Guaranteed Issue Amount:	The greater of a) or b) below: a) the lesser of 3 times Annual Compensation or \$1,000,000, or b) an amount equal to the Life Insurance Benefit in effect on the termination date of the Prior Plan
Maximum Benefit:	The lesser of 3 times Annual Compensation or \$1,500,000
Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to: 65% of the Life Insurance Benefit at age 65 50% of the Life Insurance Benefit at age 70
Continuation Options	
For Leave of Absence	
Maximum Benefit Period:	15 months
For Family Medical Leave	
Maximum Benefit Period:	12 weeks
Waiver of Premium	
Benefit Waiting Period	4 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee, his or her Spouse and Dependent Children, if any.
Terminal Illness Benefit	50% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of \$100,000.

Automatic Increase Feature

If an Employee's Life Insurance Benefit is based on Annual Compensation, it will automatically increase. The amount of the increase may be up to 10% of the Employee's previous salary. It will automatically increase, subject to the conditions below.

Conditions for Automatic Increase:

1. the Employer provides the Insurance Company with the required notice of an increase in Annual Compensation;
2. the Employee is in Active Service on the effective date of the increase; and
3. the total benefit does not exceed the Guaranteed Issue Amount.

If an Employee is not in Active Service on that date, his or her benefit will not increase until he or she returns to Active Service.

An Employee will be required to satisfy the Insurability Requirement for an increased amount if:

1. he or she initially elects a Life Insurance Benefit that is less than or equal to the Guaranteed Issue Amount and his or her benefit plus the automatic increase would exceed it, and
2. he or she has not been approved by the Insurance Company for a Life Insurance Benefit in excess of the Guaranteed Issue Amount.

An Automatic Increase will become effective on the first of the month following the Employee's increase in Annual Compensation, or if later, the date the Insurance Company approves any required Insurability Requirement.

If an Employee is initially approved for a Life Insurance Benefit in excess of the Guaranteed Issue Amount, it will not increase in excess of the Maximum Benefit Amount.

If an Employee revokes this Automatic Increase Feature, he or she may not elect it at a later date. If an Employee has not enrolled for the Automatic Increase Feature, he or she must satisfy the Insurability Requirement before any increase based on an increase in Annual Compensation becomes effective.

Re-enrollment Period

During a Re-enrollment Period, or within 31 days after a Life Status Change, an Employee currently insured under this Policy may increase his or her Life Insurance Benefit to the next higher benefit option, as long as the Benefit does not exceed the Guaranteed Issue Amount, without satisfying the Insurability Requirement. The Guaranteed Issue Amount is shown above. A Spouse or Dependent Child who is eligible for insurance under the Policy but who has not previously enrolled may become insured under the Policy without satisfying the Insurability Requirement. Such increases will be effective on the Policy Anniversary following the Re-enrollment Period or, for increases following a Life Status Change, on the date the Insurance Company receives the completed request for a Benefit increase.

An insured Employee may increase coverage for a Benefit in excess of amounts described above only if he or she satisfies the Insurability Requirement. Any excess amounts will be effective on the later of the Policy Anniversary following the Re-enrollment Period and the date the Insurance Company agrees in writing to insure the Employee.

An Employee may reduce Insurance Benefits at any time. A request for a Benefit reduction received during a Re-enrollment Period will become effective on the Policy Anniversary following the Re-enrollment Period. Any other Benefit reduction will be effective on the date the Insurance Company receives the completed change form.

Spouse or Domestic Partner Benefits

Voluntary Benefit \$5,000
Guaranteed Issue Amount: \$5,000

Terminal Illness Benefit 50% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill.

Dependent Child Benefits

Voluntary Benefit \$5,000

TL-004774

ELIGIBILITY FOR INSURANCE

Classes of Eligible Persons

A person may be insured only once under the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

Employee

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the applicable Eligibility Waiting Period, if later.

If a person has previously converted his or her insurance under the Policy, he or she will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in the Employee's Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to the Employee.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

Spouse

If an Insured is eligible to elect Spouse coverage, the Spouse is eligible to be insured on the date the Employee is eligible or the date he or she becomes a Spouse of an Employee, if later. The eligible Employee must be insured in order to elect spouse coverage.

For the purpose of eligibility, the Spouse must be the lawful Spouse of the Employee and not legally separated or divorced from, or widowed by the Employee.

Dependent Child

If an Insured is eligible to elect Dependent Child coverage, the Dependent Child is eligible to be insured on the date the Insured is eligible or on the date the child qualifies as a Dependent Child, if later.

In no event will a Dependent Child be eligible to become insured more than once under the Policy.

TL-004710

ENROLLING FOR INSURANCE

Initial Open Enrollment

During the Initial Open Enrollment Period, an Employee may become insured under the Life Insurance Plan provided by this Policy for a Benefit up to the next benefit option higher than the amount for which he or she was insured under the Prior Plan, without satisfying the Insurability Requirement, as long as the Benefit does not exceed the Guaranteed Issue Amount shown in the Schedule of Benefits. The Employee's eligible Spouse or Dependent Child may also become insured under the Life Insurance Plan without satisfying the Insurability Requirement. Coverage will not become effective for an Employee, his or her eligible Spouse or Dependent Child if an Employee is not actively at work, due to Injury or Sickness, on the date his or her coverage would otherwise become effective under this policy. Coverage will become effective on the date the Employee returns to Active Service.

If an Employee's eligible dependent is (a) an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or (b) confined to his or her home under the care of a Physician on the date insurance would otherwise be effective, it will be effective on the date the dependent is no longer an inpatient in these facilities or confined at home. If such dependent was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.

An Employee, his or her eligible Spouse or Dependent Child may become insured for an amount in excess of the Guaranteed Issue Amount only if he or she satisfies the Insurability Requirement. Any excess amount will be effective on the date the Company agrees in writing to insure that eligible person.

EFFECTIVE DATE OF INSURANCE

An Employee may elect insurance for himself or herself and an eligible Spouse or Dependent Child. If the Employee is required to contribute to the cost of the insurance, he or she must authorize payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

If an individual elects coverage within 31 days after becoming eligible to enroll, or for any increases, the Guaranteed Issue Amount will be effective on the latest of the following dates:

1. The Policy Effective Date.
2. The date payroll deduction is authorized for this insurance.
3. The date the Employer or Insurance Company receives the completed enrollment form.

If coverage is elected in an amount that exceeds the Guaranteed Issue Amount or an enrollment form is received more than 31 days after an individual is eligible to elect coverage, this insurance will be effective on the date the Insurance Company agrees in writing to insure that eligible person. The Insurance Company will require the eligible person to satisfy the Insurability Requirement before it agrees to insure him or her.

If coverage for a Dependent Child is in force and another Dependent Child is acquired, coverage for that child is effective on the date the child qualifies as a Dependent Child.

If an eligible Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

If an eligible Spouse or Dependent Child is:

1. an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility; or
 2. confined to his or her home under the care of a Physician
- on the date insurance would otherwise be effective, it will be effective on the date he or she is no longer an inpatient in these facilities or confined at home. If such Spouse or Dependent Child was covered by the Prior Plan immediately prior to the Policy Effective Date, this provision will not apply to the amount of coverage in effect as of the Policy Effective Date, but will apply to any increase in coverage.

TL-004712

Takeover Provision

Special Terms Applicable to Previously Insured Employees Not in Active Service

Employees not in Active Service on the Policy Effective Date are not covered under the Policy.

However, the Insurance Company agrees to provide a death benefit equal to the lesser of:

1. the amount due under this Policy (without regard to the Active Service provision), or
2. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

These special terms will end on the earliest of the following dates:

1. the date the Employee meets the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the Policy Effective Date; or
4. the last day the Employee would have been covered under the Prior Plan if that plan was still in force.

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TERMINATION OF INSURANCE

An Insured's coverage will end on the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which premiums are paid;
5. the date an Employee is no longer in Active Service;
6. for an Employee, Spouse and Dependent Child, the date the Employer cancels participation under the Policy; and
7. the date coverage for the Employee ends, for any insured Spouse and Dependent Child.

TL-004714

CONTINUATION OF INSURANCE

If an Employee is no longer in Active Service, he or she may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits on a class level.

Continuation for Temporary Leave of Absence or Family Medical Leave

If an Employee's Active Service ends due to an Employer approved unpaid leave of absence or family medical leave of absence, insurance will continue for up to the Maximum Benefit Period shown in the Schedule of Benefits, if the required premium is paid.

Waiver of Premium

If an Employee is under age 60 and his or her Active Service ends due to Disability, Life Insurance Benefits as shown in the Schedule of Benefits will continue until the end of the earliest of the following dates.

1. The date the Employee is no longer Disabled.
2. The date he or she no longer qualifies for Waiver of Premium.
3. The day after the period for which premiums are paid.
4. The date the Maximum Benefit Period for this benefit, if any, ends.

If an Employee dies while premiums are waived, the Insurance Company will pay a Death Benefit only if due proof of continuous Disability is received within one year of his or her death.

In order to qualify for Waiver of Premium an Employee must submit due proof that he or she has been Disabled for the Benefit Waiting Period shown in the Schedule of Benefits for this benefit. Such proof must be submitted to the Insurance Company no later than 3 months after the Employee satisfies the Benefit Waiting Period. Premiums will be waived from the date the Insurance Company agrees in writing to waive premiums for that Employee. After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if the Employee remains Disabled and submits satisfactory proof that Disability continues. Satisfactory proof must be submitted to the Insurance Company 3 months before the end of the 12 month period.

The Death Benefit will be equal to the Life Insurance Benefit in effect on the date the Employee became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce or terminate coverage because of age, retirement, acceleration or a change in eligible class. Automatic increases in Life Insurance Benefits will end while premiums are waived.

Termination of Waiver

Insurance will end for any Employee whose premiums are waived on the earliest of the following dates.

1. The date he or she is no longer Disabled.
2. The date he or she refuses to submit to any physical examination required by the Insurance Company.
3. The last day of the 12 month period of Disability during which he or she fails to submit satisfactory proof of continued Disability.
4. The date the Maximum Benefit Period for this benefit, if any, ends.

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DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

LIFE INSURANCE BENEFITS

Death Benefit

If an Insured dies, the Insurance Company will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

TL-004730

Accelerated Benefits

Any benefits payable under this Accelerated Benefits provision will reduce the Death Benefit payable for Life Insurance. Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision.

Terminal Illness Benefit

The Insurance Company will pay a Terminal Illness Benefit to an Insured who has been determined by the Insurance Company to be Terminally Ill.

The Terminal Illness Benefit is payable only once in an Insured's lifetime.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, the Insurance Company will require the Insured submit the following proof.

1. A written diagnosis and prognosis by two Physicians licensed to practice in the United States.
2. Supportive evidence satisfactory to the Insurance Company, including but not limited to radiological, histological or laboratory reports documenting the Terminal Illness.

The Insurance Company may require, at its expense, an examination of the Insured and a review of the documented evidence by a Physician of its choice.

"Terminal Illness" means a person has a prognosis of 12 months or less to live, as diagnosed by a Physician.

TL-004748

Conversion Privilege for Life Insurance

If coverage for an Insured ends for any reason, except for non-payment of premium, he or she may apply for a conversion policy of life insurance.

The conversion insurance may be a type of life insurance currently being offered for conversion by the Insurance Company at the Insured's age and in the amount requested. It may not be term insurance and it may not be for an amount greater than the Life Insurance Benefits in force under the Policy. Conversion life insurance will not provide accident, disability or other benefits.

However, if coverage ends because the Policy is terminated or amended to terminate any class of Insureds, or the Employer cancels participation under the Policy, coverage cannot be converted unless the individual has been insured under the Policy for at least 3 years. In this case, the amount of conversion insurance will be the lesser of the Life Insurance Benefit in force under the Policy, or \$10,000.

To apply for conversion insurance, the Insured must within 31 days after coverage under the Policy ends, submit an application to the Insurance Company and pay the required premium. Evidence of insurability is not required. Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends, if the application is received by the Insurance Company and the required premium is paid on that date.

If the Insured dies during the 31 day conversion period, the Death Benefit will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any benefits payable for that type and amount of insurance under the Policy.

Extension of Conversion Period

If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31 day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance Benefits will not be paid under the Policy. If the Insured's application for conversion insurance is received by the Insurance Company and the required premium is paid, Life Insurance Benefits will be payable under the conversion insurance.

Prior Conversion Limitation

If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in the Insured's Life Insurance Benefits based on age or a change in class.

TL-004750

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Written notice or any other electronic/telephonic means authorized by the Insurance Company of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice or any other electronic/telephonic means authorized by the Insurance Company was given as soon as reasonably possible.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or any other electronic/telephonic means authorized by the Insurance Company, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, the Insurance Company will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment

Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable

Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

All benefits payable under the Accelerated Benefits section are payable to the Insured, if living. If the Insured dies prior to the payment of an eligible claim for an Accelerated Benefit, benefits will be paid in accordance with the provisions applicable to the payment of Life Insurance proceeds, unless the Insured has directed us otherwise in writing. However, any payment made by us prior to notice of the Insured's death shall discharge us of any benefit that was paid.

All other benefits, unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at the Insured's death may, at the Insurance Company's option, be paid either to the Insured's beneficiary or to the executor or administrator of the Insured's estate.

If the Insurance Company pays benefits to the executor or administrator of the Insured's estate or to a person who is incapable of giving a valid release, the Insurance Company may pay up to \$1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary

The Insured may change the beneficiary at any time by giving written notice to the Employer or the Insurance Company. The beneficiary's consent is not required for this or any other change which the Insured may make unless the designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or the Insurance Company. When this form is received, it will take effect as of the date of the form. If the Insured dies before the form is received, the Insurance Company will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy

The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship

The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724

ADMINISTRATIVE PROVISIONS**Premiums**

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to acceleration of his or her Death Benefit, his or her premium will be based on the amount of coverage he or she has in force on the day before the reduction took place. If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 36 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements

The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium

The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation

The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period

A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Grace Period for the Insured

If the required premium is not paid on the Premium Due Date, there is a 31 day grace period after each premium due date after the first. If the required premium is not paid during the grace period, insurance will end on the last day for which premium was paid.

If benefits are paid during the Grace Period for the Insured, the Insurance Company will deduct any overdue premium from the proceeds payable under the Policy.

Reinstatement of Insurance

Coverage may be reinstated without satisfying the Insurability Requirement, if an Employee's insurance ends because he or she is on an unpaid leave of absence and he or she applies for Reinstatement within 31 days of his return to Active Service.

After an Insured's coverage has ceased, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met:

1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

TL-004720

SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR EMPLOYEE BENEFITS

Life Insurance

For amounts of insurance
up to 2 times Annual Compensation: \$.15 Per \$1,000

For amounts of insurance in excess
of 2 times Annual Compensation:

Monthly Rates are based on units of \$1,000

Under Age 20	\$.03	Age 50 - 54	\$.23
Age 20 - 24	\$.04	Age 55 - 59	\$.43
Age 25 - 29	\$.04	Age 60 - 64	\$.66
Age 30 - 34	\$.05	Age 65 - 69	\$1.13
Age 35 - 39	\$.08	Age 70 - 74	\$2.06
Age 40 - 44	\$.10	Age 75 - 79	\$2.06
Age 45 - 49	\$.15	Age 80 and over	\$2.06

A change in rates due to a change in the Employee's age will become effective on the Policy Anniversary Date coinciding with or following the Employee's birthday.

FOR SPOUSE OR DOMESTIC PARTNER AND DEPENDENT CHILD BENEFITS

Voluntary Life Insurance \$2.00 Per Family Unit

TL-004718

GENERAL PROVISIONS

Entire Contract

The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age

If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes

No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates

A certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits

The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency

The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident

An Accident is a sudden, unforeseeable external event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Active Service

An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time or Part-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Annual Compensation

An Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. Annual Compensation also includes 401(a) contributions, if any, for that year. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.

Dependent Child

An Employee's unmarried child who meets the following requirements.

1. A child from live birth to 21 years old;
2. A child who is 21 or more years old but less than 25 years old, enrolled in a school as a full-time student and primarily supported by the Employee;
3. A child who is 21 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Insurance Company within 31 days after the date the child ceases to qualify as a Dependent for the reasons listed above. During the next two years, the Insurance Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Insurance Company may require proof no more than once a year.

The term "child" means a child born to or legally adopted by the Employee. The term includes a child during any waiting period prior to the finalization of the child's adoption. It also means a stepchild, including a Domestic Partner's child, living with and financially dependent upon the Employee.

Disability/Disabled

An Employee's inability, due to Sickness or accidental Injury, to work at any occupation suited to his or her education, training or experience.

Employee

For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer

The Employer who has subscribed to the Policyholder and for the benefit of whose Employees this policy has been issued. The Employer, named as the Subscriber on the front of this Policy, includes any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Flexible Benefits Plan

The Flexible Benefits Plan is the Employee Benefits Plan arrangement sponsored by the Employer for eligible Employees and their eligible dependents.

Full-time

Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Injury

Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurability Requirement

An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company

The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured

A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Life Status Change

A Life Status Change is an event recognized by the Employer's Flexible Benefits Plan as qualifying an Employee to make changes in benefit selections at a time other than an Annual Enrollment Period.

If there is no Employer sponsored Flexible Benefits Plan, or if it is no longer in effect, the following events are Life Status Changes.

1. Marriage
2. Divorce, annulment or legal separation
3. Birth or adoption of a child
4. Death of a spouse
5. Termination of a spouse's employment
6. A change in the benefit plan available to the Employee's spouse
7. A change in the Employee's or his or her spouse's employment status that affects either person's eligibility for benefits

Part-time

Part-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date.

Sickness

Any physical or mental illness.

Spouse

The current lawful Spouse of an Employee.

TL-004708

Life Insurance Company of North America
a stock insurance company

Rider to Group Policy No. FLI-960054
Effective Date of Rider: January 1, 2006

Eligible Classes to which this Rider applies: All Classes

**MODIFICATION OF GROUP POLICY
TO ADD DOMESTIC PARTNER AS AN ELIGIBLE DEPENDENT
UNDER THE GROUP POLICY FOR TERM LIFE INSURANCE**

The provisions of the Policy are modified as follows:

1. All references to the term "Spouse" are replaced by "Spouse or Domestic Partner", except for the following references:
 - a. The definition of "Spouse" remains unchanged.
 - b. Any reference to "lawful spouse" or "legal spouse" remains unchanged.
 - c. Any reference to "Spouse" remains unchanged in the paragraph entitled "To Whom Payable" under the Claims Provisions.
 - d. Any reference to "Spouse" in the "Life Status Change" definition remains unchanged.
2. The following Domestic Partner definition is added to the Definitions section of the Group Policy.

For Employees who reside in the state of California, "Domestic Partner" means a person who is registered as the Employee's domestic partner with the California Secretary of State.

For Employees other than those who reside in the state of California, "Domestic Partner" means a person who meets the following requirements:

- a. shares the Employee's permanent residence.
- b. agrees with the Employee to be jointly responsible for each other's basic living expenses. Basic living expenses are defined as the cost of basic food, shelter, and any other living expenses. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.
- c. has not signed a domestic partner declaration with any other person.
- d. is no less than 18 years of age.
- e. is not legally permitted to marry the Employee.
- f. is not currently legally married to any other person.
- g. is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress, or fraud.

An Employee's Domestic Partner is eligible for Life Insurance Benefits under the Policy on the later of the Employee's eligibility date or the date the person becomes the Employee's Domestic Partner and if all the following conditions are met.

- a. For domestic partnerships registered with the California Secretary of State, the Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Employee.

- b. For domestic partnerships not registered with the California Secretary of State:
 - i. The Employee is not married to any person.
 - ii. The Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the Employee.
 - iii. The Employee and the Domestic Partner furnish a notarized affidavit or signed statement reflecting these requirements, and an agreement to notify the Insurance Company if the requirements cease to be met, on a form acceptable to the Insurance Company.

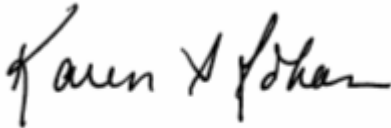
To obtain insurance for a Domestic Partner, an Employee must request coverage in writing and agree to make any required premium contributions. Insurance will be effective for a Domestic Partner on the same date specified for a Spouse in the Effective Date of Insurance Provision.

The amount of insurance that applies to a Domestic Partner is shown in the Schedule of Benefits.

Death benefits with respect to any Domestic Partner will be payable to the beneficiary chosen by the Domestic Partner. If no beneficiary is named, benefits are payable to the Employee.

Except for the above, this Rider does not change the Group Policy to which it is attached.

Life Insurance Company of North America



Karen S. Rohan, President

By:

TL-007152-2.05

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Insurance Company)

AMENDATORY RIDER

**CLAIM PROCEDURES APPLICABLE TO PLANS SUBJECT TO THE
EMPLOYEE RETIREMENT INCOME SECURITY ACT (“ERISA”)**

The provisions below amend the Policy to which they are attached. They apply to all claims for benefits under the Policy. They supplement other provisions of the Policy relating to claims for benefits.

This Policy has been issued in conjunction with an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 (“ERISA”). This Policy is a Plan document within the meaning of ERISA. As respects the Insurance Company, it is the sole contract under which benefits are payable by the Insurance Company. Except for this, it shall not be deemed to affect or supersede other Plan documents.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for deciding claims for benefits under the Plan, and for deciding any appeals of denied claims.

Review of Claims for Benefits

The Insurance Company has 45 days from the date it receives a claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. If this should happen, the Insurance Company must provide notice in writing that its review period has been extended for:

- (i) up to two more 30 day periods (in the case of a claim for disability benefits); or
- (ii) 90 days more (in the case of any other benefit).

If this extension is made because additional information must be furnished, these extension periods will begin when the additional information is received. The requested information must be furnished within 45 days.

During the review period, the Insurance Company may require:

- (i) a medical examination of the Insured, at its own expense; or
- (ii) additional information regarding the claim.

If a medical examination is required, the Insurance Company will notify the Insured of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit.

If the claim is denied, in whole or in part, the Insurance Company will provide written notice within the review period. The Insurance Company's written notice will include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for the claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit: identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.

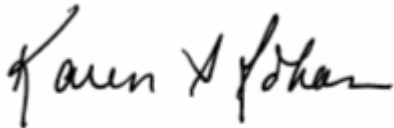
5. A statement regarding the right to appeal the decision, and an explanation of the appeal procedure, including a statement of the right to bring a civil action under Section 502(a) of ERISA if the appeal is denied.

Appeal Procedure for Denied Claims

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days (45 days, in the case of any disability benefit) from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any disability benefit). Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.



Karen S. Rohan, President

TL-009000

**LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235**

We, The Scripps Research Institute, whose main office address is La Jolla, CA, hereby approve and accept the terms of Group Policy Number FLI-960054 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA to the TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE SERVICES INDUSTRY.

This form is to be signed in duplicate. One part is to be retained by The Scripps Research Institute; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

The Scripps Research Institute

Signature and Title: _____ Date: _____

(This Copy Is To Be Returned To Life Insurance Company of North America)

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PHILADELPHIA, PA 19192-2235**

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