YOUR GROUP
TERM LIFE BENEFITS

FOR MEMBERS OF:

Tongass Timber Trust

CLASS(ES):

All Eligible Members

REVISION EFFECTIVE DATE:

January 1, 2014

PUBLICATION DATE:

February 6, 2014

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF ALASKA.

FRAUD WARNING
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G0003K78

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Participating Employer or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-3K78 (the Policy) has been issued to Tongass Timber Trust (the Policyholder).

Insurance is provided for Members of the Policyholder subject to the terms and conditions of the Policy.

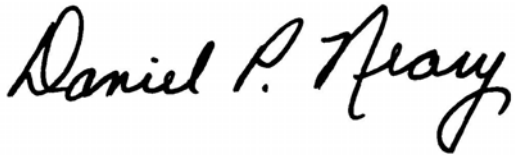
Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

The Policy provides Group Term Annually Renewable Life Insurance. The Policy is non-participating, therefore it will pay no dividends. The Policy is noncontributory.

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer

Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All Eligible Members

LIFE INSURANCE FOR YOU (THE MEMBER)

Your amount of life insurance is $13,000.

If You have questions regarding the amount of Your life insurance, You may contact the Policyholder or Participating Employer.

LIFE INSURANCE FOR YOUR DEPENDENT(S)

You may elect to have Your Spouse insured for an amount of life insurance equal to $2,000.

You may elect to insure Your eligible Dependent child(ren). If elected, the amount of life insurance for Your eligible Dependent child(ren) is based on the age of the Dependent, as follows:

Age of Dependent Child	Amount of Life Insurance
Six months and older	$2,000
14 days to less than six months	$500

If You have questions regarding the amount of life insurance for Your Dependent(s), You may contact the Policyholder or Participating Employer.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule. If You have questions regarding the amount of Your AD&D insurance, You may contact the Policyholder or Participating Employer.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee Issue Amount(s) is/are subject to any reductions indicated in the Benefit Reductions provision of this Schedule.

Guarantee Issue Amount For You (The Member)

Your Guarantee Issue Amount is $13,000.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for Your Spouse is $2,000.

Guarantee Issue Amount For Your Dependent Child(ren)

The Guarantee Issue Amount for Your Dependent child(ren) is $2,000.

Insurance for Your Dependent(s), if applicable, is only available on a guarantee issue basis:

a) during the First Enrollment Period;
b) during a Subsequent Enrollment Period; or
c) as otherwise stated or allowed in the Policy.

Evidence of Insurability

Evidence of Insurability is not required for any amount of insurance for You, unless otherwise stated in the Policy.

Evidence of Insurability is required for insurance elected more than 31 days after the date a Dependent becomes eligible, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy. If Evidence of Insurability is required, We may require that such evidence be provided at Your expense.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

Actively Working, Active Work means a Member is performing the normal duties of his or her regular job for the Policyholder or Participating Employer on a regular and continuous basis for 130 or more hours each month. A Member will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Member was actively working on the last preceding regular work day.

Disability Elimination Period means the period of time that must be satisfied before You are eligible to continue benefits, beginning on the date Your Injury or Sickness occurred. The length of the disability elimination period is shown in the Continuation of Insurance for Total Disability with Waiver of Premium provision.

Eligibility Waiting Period means a continuous period of Active Work that a Member must satisfy before becoming eligible for insurance as described in the When a Member Becomes Eligible for Insurance (Eligibility Waiting Period) provision.

Life Event means:

a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents; or
c) a significant cost or coverage change under any other employer or group sponsored life plan under which You or Your Dependent(s) are covered.

Recurrent Disability means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

Total Disability, Totally Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

WHEN A MEMBER BECOMES ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

A Member who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

A Member who is not eligible for insurance under the Policy on the Policy Effective Date, or a Member who is hired after the Policy Effective Date, becomes eligible for insurance under the Policy after the Member has worked 130 or more hours a month for a Participating Employer for two consecutive months.

The day on which a Member becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

A Dependent becomes eligible for insurance under the Policy on the later of:

a) the day You become eligible for insurance under the Policy; or
b) the day You acquire the Dependent.

If both You and Your Spouse are eligible for insurance under the Policy as Members, neither You nor Your Spouse may elect insurance as a Dependent of the other person.

If both You and Your Spouse are eligible for insurance under the Policy as Members, either You and Your Spouse, but not both, may elect insurance for Your Dependent child(ren) under the Policy.

The day on which a Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN INSURANCE BEGINS

A Member will become insured on the latest of the day:

a) the Member becomes eligible and is Actively Working; or
b) the Member submits a Written Request to enroll for insurance, if applicable.

An eligible Member must enroll for insurance for any Dependent(s) by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder or Participating Employer within 31 days following the day the Dependent(s) become(s) eligible. If the Written Request for insurance is not submitted within 31 days following the day the Dependent(s) become(s) eligible for insurance, the Evidence of Insurability will be required for the Dependent(s).

An eligible Dependent will become insured on the latest of the day:

a) the Member becomes insured, unless otherwise agreed to by Our authorized representative in Our home office;
b) the Member acquires the eligible Dependent;
c) the Member submits a Written Request to enroll the Dependent for insurance, if applicable; or
d) We approve Evidence of Insurability, if required.

An eligible Member or Dependent must provide Evidence of Insurability if it is required. An eligible Member or Dependent will become insured for any amount of insurance that requires Evidence of Insurability on the first day of the month that follows the day We approve Evidence of Insurability.

THE FIRST ENROLLMENT PERIOD

A Member may elect insurance for any Dependent(s) during the First Enrollment Period.

If a Member does not elect insurance during the Dependent's First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

A Member may elect, drop, increase, decrease or change insurance for any Dependent(s) during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

A Member may elect, drop, increase, decrease or change insurance for any Dependent(s) as allowed by the Policyholder. Any election of or increase in insurance for a Dependent will require Evidence of Insurability unless otherwise stated or allowed in the Policy.

Life Events

Within 31 days of a Life Event, You may submit a Written Request to change insurance.

If You experience a Life Event, insurance for any Dependent(s) may be issued without Evidence of Insurability. If the Written Request is submitted more than 31 days after the date of a Life Event, We will require Evidence of Insurability.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your or Your Dependent's class or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later.

For any increase in insurance, We will use the Policyholder or Participating Employer's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended for You and/or Your Dependent(s) in accordance with this provision.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date You become eligible for insurance, the date of the of the Written Request for Dependent insurance, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Rehired Member Due to Layoff or Termination

If insurance ended because the Member was no longer Actively Working due to layoff or termination from employment with the Policyholder or a Participating Employer, insurance may be reinstated if the Member resumes employment with the Policyholder or any Participating Employer within 30 days from the date insurance ended.

Transfer From Conversion

If insurance was obtained under the Conversion provision while a Member was not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any Conversion Policy(ies) issued to You or any of Your Dependent(s) must be surrendered to Us. If Conversion Policy(ies) are not surrendered, Evidence of Insurability will be required to reinstate insurance.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) an Insured Person is no longer eligible for insurance under the Policy; or
b) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less).

Insurance will also end:

a) on the day the Participating Employer withdraws from participation with the Policyholder;
b) on the day the Policy terminates; or
c) in accordance with the Grace Period provision.

Insurance that has ended may only be reinstated as allowed under the Reinstatement of Insurance provision. Unless allowed in this provision, a Member that was previously insured can only become insured again by satisfying the requirements of the Policy as a newly hired Member, as described in the When a Member Becomes Eligible for Insurance (Eligibility Waiting Period) provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You or any of Your Dependent(s) cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You or any of Your Dependent(s), and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and/or Your Dependents would otherwise end, You and/or Your Dependents may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Total Disability with Waiver of Premium
c) Conversion

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff;
b) a leave of absence approved by the Policyholder or Participating Employer due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder or Participating Employer for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. the last day of the month following the month in which Your layoff occurred, for Your temporary involuntary layoff;
    2. 3 months for Your leave of absence; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision; and
c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder or Participating Employer; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

This provision only allows for continuation of life insurance under the Policy. Accidental death and dismemberment insurance may not be continued under this provision.

You may be able to continue insurance under this provision from the day You cease to be Actively Working due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to Us, Your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Totally Disabled;
b) You were under age 60 at the time You became Totally Disabled;
c) the Disability Elimination Period is satisfied; and
d) proof of Total Disability is provided to Us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

Insurance may only be continued for You. If You are able to continue insurance under this provision, Your Dependent(s) may be able to obtain insurance under the Conversion provision.

If You are age 60 or older and become Totally Disabled, You and Your Dependent(s) may be able to obtain insurance under the Conversion provision.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

About the Disability Elimination Period

The Disability Elimination Period is a period of 9 consecutive months. Your insurance will continue during the Disability Elimination Period provided premiums are paid by You or on Your behalf when due.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

Proof of Total Disability

You must submit to Us acceptable proof of Total Disability approved by Our authorized representative in Our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense.

If You are approved for continuation of insurance under this provision, We will periodically require proof of continuing Total Disability. We may have You examined by a Physician of Our choice at any time during the first two years of Total Disability and once a year thereafter at Our expense. If an additional examination is required due to questionable or disputed results of an examination, any additional examination may be at Your expense.

When Continuation of Insurance for Total Disability is Approved

We will notify You in writing if Your proof of Total Disability is approved by Us. Any premium paid for Your insurance from the day You ceased to be Actively Working will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Disability Elimination Period if:

a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
b) Your Recurrent Disability occurs within 6 months of the end of Your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

We will notify You in writing if Your proof of Total Disability is not approved by Us. If at any time while You are insured under this provision We determine that You are no longer Totally Disabled, We will notify You in writing that You are no longer eligible to continue insurance under this provision.

If You are ineligible for insurance under this provision or Your insurance under this provision ends, You and Your Dependent(s) will have 31 days from the date of Our notice to submit a Written Request for insurance under the Conversion provision, if You have not returned to Active Work.

When Insurance Under this Provision Ends

Insurance under this provision will end on the day You return to Active Work.

Insurance under this provision will also end on the earliest of the day:

a) You are no longer Totally Disabled;

b) that is 90 days after the date of Our request to You for proof of Total Disability if such proof has not been received by Us;
c) You fail to obtain an examination from a Physician of Our choice as described in the Proof of Total Disability provision by a date established by Us;
d) You reach age 65; or
e) You begin full-time employment with an employer other than the Policyholder or Participating Employer.

In no event will insurance under this provision end less than one year from the day Your Total Disability is approved by Us.

CONVERSION

This provision allows for conversion of life insurance. Conversion insurance is not available for accidental death and dismemberment insurance.

When Membership Ends

If group life insurance ends because Your membership in a class (as shown under Class(es) on the Schedule), You may apply for an individual policy of life insurance other than term insurance ("Conversion Policy"). If group life insurance for any of Your Dependent(s) ends due to Your death, divorce, legal separation or failure to satisfy any other eligibility condition, Your Dependent(s) may also apply for a Conversion Policy.

The Conversion Policy issued under this provision will be:
a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits; and
c) for an amount of life insurance that is up to the amount of life insurance that ended, less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended or was reduced.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates

You and/or Your Dependent(s) may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:
a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits;
c) for an amount of life insurance that does not exceed the lesser of:
    1. $10,000; or
    2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces ("Conversion Period"). When insurance ends under the Policy, notice of the right to convert will be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:
a) 15 days after notice has been received; or
b) 60 days after the end of the Conversion Period, even if notice is not received.

If You or any of Your Dependent(s) are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You or Your Dependent(s) did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You or Your Dependent(s) must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If You or any of Your Dependent(s) are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us. If Conversion Policy(ies) are not surrendered, Evidence of Insurability will be required.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued, We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder or Participating Employer may pay the premiums; or
b) You may pay premium to the Policyholder or Participating Employer who will then submit premium to Us.

Contact the Policyholder or Participating Employer to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 45 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 45-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance for You and/or Your Dependents will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for You and/or Your Dependents will terminate during the grace period. If We receive such notice, insurance will terminate for You and/or Your Dependents on the date requested.

If any premium due is not paid during the grace period, insurance for You and/or Your Dependents will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance for You and/or Your Dependents, the Policyholder or Participating Employer will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for You and/or Your Dependents in accordance with the terms of the Policy, or a change in the amount of insurance for You and/or Your Dependents as the result of a request of the Policyholder or Participating Employer, the Policyholder or Participating Employer will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if premium rates under the Policy are changed.

LIFE INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You or any of Your Dependent(s), if applicable. Benefits payable by reason of Your death will be paid to Your beneficiary. Benefits payable by reason of the death of Your Dependent(s), if applicable, will be paid to You.

BENEFICIARY DESIGNATION

At the time You become insured or elect insurance under the Policy, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect will be accepted as a beneficiary designation under the Policy.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

a) Your surviving Spouse; if none, then to
b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
c) Your surviving parent(s), in equal shares; if none, then to
d) Your surviving brother(s) and sister(s), in equal shares; if none, then to
e) Your estate.

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

You are the beneficiary of Your Dependent(s) benefits. If You are not living at the time of the death of any of Your Dependent(s), the following will apply:

a) In the event of the death of Your Spouse, benefits will be paid to Your Spouse's estate.
b) In the event of the death of any of Your Dependent child(ren), benefits will be paid to Your Spouse, if Your Spouse is living. If Your Spouse is not living, benefits will be paid in equal shares to the deceased child's living siblings. If there are no living siblings, benefits will be paid to the estate of the deceased child.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then You may send the Written Request to Us. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

FACILITY OF PAYMENT

We may pay an amount of up to $4,000 to any person or entity that has incurred expenses related to Your death and subsequent burial, or to the death and subsequent burial of any of Your Dependent(s), if applicable. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

This rider is made a part of Group Policy GLUG-3K78. It is subject to all of the Policy provisions which are not inconsistent with the provisions of this rider.

This rider is effective the later of the Policy Effective Date or the day You become insured under the Policy.

Capitalized terms used in this rider have the meanings assigned to them in this rider or in the other sections of the Policy.

DEFINITIONS

Accident means an external, sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes. Accident does not include Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. Accident does include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

Family means Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses of such individuals.

Intoxicated means having a blood alcohol level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.

Loss of a Hand or Foot means Severance of at least four whole fingers from one hand or Severance of the foot above the ankle joint.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Sight means total and permanent loss of sight of the eye which cannot be corrected by any means.

Loss of Speech means total and permanent loss of audible communication which cannot be corrected by any means.

Loss of a Thumb and Index Finger means Severance at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

Severance means the complete separation and dismemberment of the part from the body.

Traveling on Business of the Policyholder or Participating Employer means any trip made by You on assignment by or with authorization of the Policyholder or Participating Employer for the purpose of furthering the business of the Policyholder or Participating Employer. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing him or her to operate the aircraft.

EXPOSURE AND DISAPPEARANCE

An Insured Person will be presumed to have died, for the purposes of accidental death and dismemberment insurance, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

BENEFITS

Basic Benefits

In the event of a loss while insured under the Policy, We will pay accidental death and dismemberment benefits based upon the amount of the Principal Sum in effect at the time of the loss for You. Benefits for Your insurance will be payable to You or to the beneficiary for life insurance under the Policy.

If an Insured Person is Injured or dies as a result of an Accident, We will pay the benefit shown in the following Table. If an Accident causes more than one loss shown in the Table, We will pay only the largest benefit.

Accidental Death and Dismemberment Benefits Table (the "Table")

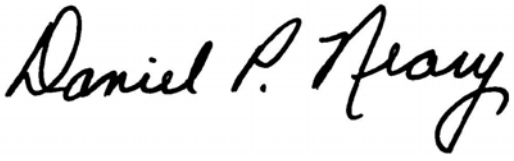
Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum

EXCLUSIONS

We will not pay for any loss which:

a) results, whether the Insured Person is sane or insane, from:
   1. an intentionally self-inflicted Injury or Sickness; or
   2. suicide or attempted suicide;
b) results from the Insured Person's Participation in a Riot or in the commission of a felony;
c) results from an act of declared or undeclared war or armed aggression;
d) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
e) is not permanent, unless specifically provided;
f) occurs more than 365 days after the Injury;
g) does not result from an Accident;
h) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
i) results from Injuries the Insured Person receives in any aircraft while operating, riding as a passenger, boarding or leaving, unless riding as a passenger in a commercial aircraft on a regularly-scheduled flight or while You are Traveling on Business of the Policyholder or Participating Employer;
j) results from an Injury received while riding in any aircraft engaged in:
   1. racing;
   2. endurance tests;
   3. acrobatic or stunt flying;
k) is caused by the Insured Person, and is a result of Injuries received while under the influence of any controlled drug, unless administered on the advice of a Physician;
l) is caused by the Insured Person and is a result of Injuries the Insured Person receives while voluntarily Intoxicated.

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLAIM FORMS

Before benefits are paid, We must be given written proof of loss as described in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Benefits Administrator
111 Stedman Street, Suite 200
Ketchikan, AK 99901

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays; and
d) other diagnostic aids.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section and/or Accidental Death and Dismemberment Benefits Rider.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum. Accidental death and dismemberment benefits will be available in one lump sum unless otherwise indicated in the Accidental Death and Dismemberment Benefits Rider.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to recover any payments due to:

a) fraud or misrepresentation; or
b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

CLAIM REVIEW AND APPEAL PROCEDURES

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If You have any questions, please contact Us.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You or Your Dependent(s).

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

MISSTATEMENT OF AGE OR GENDER

If an Insured Person's age or gender is misstated, We may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age or gender.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild; or
d) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured under the Policy as a Member;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less); or
c) Your divorced, legally separated or former Spouse;
d) a child less than 14 days old;
e) a child who has reached the age of 26 unless the child is Incapacitated;
f) Your child if the child has been legally adopted by another person; or
g) a child placed in Your home by a social service agency which retains control over the child.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

First Enrollment Period means the 31-day period following the day a Dependent becomes eligible for insurance under the Policy.

Guarantee Issue Amount means the amount of life insurance We may issue without requiring Evidence of Insurability.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated means that a Dependent child is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical handicap.

Injured means the occurrence of an Injury.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Insured Person(s) means You and/or Your Dependent(s) who are insured under the Policy.

Member means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder or Participating Employer for work performed for the Policyholder or Participating Employer at:
    1. the Policyholder or Participating Employer's usual place of business;
    2. an alternative work site at the direction of the Policyholder or Participating Employer; or
    3. a location to which the employee must travel to perform the job.

A member does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office; or

b) performing services for the Policyholder or Participating Employer as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder or Participating Employer and a leasing organization.

Our, We, Us means United of Omaha Life Insurance Company.

Participating Employer means an employer that participates in the Tongass Timber Trust and makes contributions to the Policyholder on Your behalf for the insurance plans offered by the Policyholder.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2014.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Schedule means the section of the Certificate identified as the "Schedule".

Sickness means a disease, disorder or condition that requires treatment by a Physician.

Spouse means the person to whom You are legally married.

Subsequent Enrollment Period means any period of up to 31 consecutive calendar days designated for enrollment under the Policy by the Policyholder and agreed to in writing by Our authorized representative in Our home office.

Written Request means a request that is signed, dated and submitted to the Policyholder, Participating Employer or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

You, Your means the Member who is insured under the Policy.

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ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with Your Certificate, is Your ERISA Summary Plan Description for the insurance benefits described herein.

Contributions are made by the Policyholder and by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The benefits under the Plan are fully insured by United of Omaha Life Insurance Company under a group insurance policy issued by United of Omaha Life Insurance Company. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). The home office for United of Omaha Life Insurance Company is located at Mutual of Omaha Plaza, Omaha, NE 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

Name of Plan is: Tongass Timber Trust
Type of Plan: This Plan is a welfare plan covering: Life and Accidental Death and Dismemberment
The Employer Identification Number (EIN) is: 92-002302
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Board of Trustees, Tongass Timber Trust
Alaska Forest Association, Inc.
111 Stedman Street, Suite 200
Ketchikan, AK 99901
Phone: (907) 225-6114
Fax: (907) 225-5920
E-mail: benefits@akforest.org

BOARD OF TRUSTEES

Keaton Gildersleeve, Chairman
Gildersleeve, Inc.
14750 SW Springhill Road
Gaston, OR 97119

Jerry Larrabee
Larrabee Logging
PO Box 5233
Carefree, AZ 85377

Leo Gellings
Phoenix Logging
PO Box 5758
Ketchikan, AK 99901

George Baggen
Samson Tug and Barge
PO Box 559
Sitka, AK 99835

Linda Lewis
Phoenix Logging
PO Box 5758
Ketchikan, AK 99901

Bob Byers
Tongass Cutting LLC
PO Box 1890
Petersburg, AK 99833

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is the Executive Director of the Alaska Forest Association, Inc. In addition, service of process may be made upon the Plan Administrator.

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the 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:

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer 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.

c) Enforce Your Rights

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

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

d) Assistance with Your Questions

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

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;

c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

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Group Term Life Benefits

Tongass Timber Trust

Group Number: G0003K78

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175