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GROUP BOOKLET-CERTIFICATE FOR MEMBERS OF

FISHEYE SOFTWARE, INCORPORATED

ALL MEMBERS
Group Member Life Insurance

Print Date: 02/18/2003

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Your coverage has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

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

The effective date of your coverage is as shown on your enrollment form. You should keep your enrollment form, any change of beneficiary or change of name forms, or other similar forms with your booklet after the form has been recorded by Us and returned to you.

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

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the coverage.

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

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

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

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

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

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

PRINCIPAL LIFE INSURANCE COMPANY Des Moines, IA 50392-0001

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SUMMARY OF BENEFITS
(effective February 1, 2003)

This section highlights the benefits provided under this coverage. The purpose is to give you quick access to the information you will most often want to review**. Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

MEMBER LIFE INSURANCE

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

Class	***Basic Scheduled Benefit**
All Members	The amount that is equal to 1 times your Basic Annual Compensation (this amount will be rounded to the next higher $1,000, if it is not already an exact multiple of $1,000).

The Maximum Scheduled Benefit amount will be $150,000 and the Minimum Scheduled Benefit amount will be $15,000 subject to the reduction provision below.

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

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

For the age(s) shown below, the amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below.

Age	**% of Scheduled Benefit (or approved amount)**
Age 70 but less than age 75	65%
Age 75 and over	45%

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If you are injured and otherwise qualify, We will pay the following percentages of your

Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if you lose a hand, a foot, or the sight of one eye; or
- 100% if more than one of the listed losses results from the same accident; or
- 100% if you lose your life.

Payment for loss of life will be to your beneficiary or as otherwise provided in the Death Benefit provision. Payment for any other loss will be to you. The Scheduled Benefit is based on your class:

Class	***Basic Scheduled Benefit**
All Members	The amount that is equal to 1 times your Basic Annual Compensation (this amount will be rounded to the next higher $1,000, if it is not already an exact multiple of $1,000).

The Maximum Scheduled Benefit amount will be $150,000 and the Minimum Scheduled Benefit amount will be $15,000 subject to the reduction provision below.

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

For the age(s) shown below, the amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below.

Age	**% of Scheduled Benefit (or approved amount)**
Age 70 but less than age 75	65%
Age 75 and over	45%

HOW TO BE COVERED - MEMBERS

MEMBER LIFE INSURANCE

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Eligibility

To be eligible for coverage you must be a Member.

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

If you are a Member on February 1, 2003, you will be eligible on that date.

If you are not a Member until later, you will be eligible on the first of the insurance month coinciding with or next following the date you begin Active Work.

Effective Dates - Actively at Work

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

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

- are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and

- were Actively at Work on their last scheduled work day before the date of their absence; and

- were capable of Active Work on the day before the scheduled effective date of their insurance or change in their insurance, whichever is applicable.

Individual Incontestability

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

- the coverage has been in force for less than two years during the covered person's lifetime; and

- the statement is in written form signed by the covered person; and

- a copy of the form which contains the statement is given to the covered person or the covered person's beneficiary at the time coverage is contested.

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

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

Assignments

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

Proof of Good Health

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

- If you are eligible to become insured on the date your Policyholder's plan is effective (except if a guarantee issue amount applies as agreed to by your Policyholder and Us). We will pay the reasonable cost of proof required in this instance.

- If you request coverage more than 31 days after the date you are eligible including any coverage you refuse and later request. You must pay the cost of obtaining proof in this instance.

- If you have failed to provide required Proof of Good Health or you have been refused coverage under the Group Policy at any prior time. You must pay the cost of obtaining proof in this instance.

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

- To become insured, initially or through future increases, for any Member Life (and Member Accidental Death and Dismemberment) Insurance Scheduled Benefit amount in excess of $150,000.

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

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

If you are required to contribute toward the cost of your coverage, your coverage will normally be in force on:

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

- the first of the insurance month coinciding with or next following the date of your

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

If you are not required to contribute toward the cost of your coverage, your coverage will normally be in force on the date you are eligible.

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

Effective Date for Initial Coverage
(Proof of Good Health Required)

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

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

- the first of the insurance month coinciding with or next following the date Proof of Good Health is approved by Us.

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

Effective Date for Benefit Changes
(Proof of Good Health Not Required)

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

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

If Proof of Good Health is not required, a change in your Scheduled Benefit amount because of a request by you will normally be effective on the first of the insurance month coinciding with or next following the date of the request. However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

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

Effective Date for Benefit Changes

(Proof of Good Health Required)

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

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

- the first of the insurance month coinciding with or next following the date Proof of Good Health is approved by Us.

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

Termination

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

- the date the Group Policy terminates; or

- the end of the insurance month in which you cease to belong to a class for which coverage is provided; or

- the end of the insurance month in which you cease to be a Member; or

- the end of the insurance month in which you cease Active Work.

Termination for Fraud

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

- In writing and with 31 day notice, if you submit any claim that contains false or fraudulent elements under state or federal law;

- In writing and with 31 day notice, upon finding in a civil or criminal case that you have submitted claims that contain false or fraudulent elements under state or federal law;

- In writing and with 31 day notice, when you have submitted a claim which, in good faith judgement and investigation, you knew or should have known, contains false or fraudulent elements under state or federal law.

Coverage While Outside of the United States

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

- travel, provided the travel is for a reason other than securing health care diagnosis or treatment; or

- a business assignment

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

Continuation

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

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

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

If you are interested in continuing your coverage beyond the date it would normally terminate, you should consult with the Policyholder before your coverage terminates.

Continuation

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

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

FMLA and Other Continuation Provisions

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

- are in addition to any other continuation provisions of the Group Policy, if any; and

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

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

Eligible Employer

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

Eligible Employee

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

- for at least 12 months; and

- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and

- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

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

Mandated Unpaid Leave

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

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

Reinstatement

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

Reinstatement of Coverage for you When Coverage Ends due to Living Outside of the United States

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

- you return to the United States within three months of the date on which coverage terminated because you are outside of the United States; and
- you return to Active Work in the United States for the Policyholder for a period of at least 30 consecutive days. You will be eligible for coverage on the day immediately following completion of the 30 consecutive days of Active Work.

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

See your employer for details on this reinstatement provision.

DESCRIPTION OF BENEFITS

MEMBER LIFE INSURANCE

Death Benefit

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

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

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

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

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

Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may later change your beneficiary by filing a written request with Us. See the Policyholder for change request forms. A change in your beneficiary will not be in force until We record the change.

Continuation (Member Life Insurance - Coverage During Disability)

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Totally Disabled, you might qualify to continue your Member Life Insurance and Member Accidental Death and Dismemberment Insurance. This continuation is called Coverage During Disability.

To be qualified for Coverage During Disability, you must:

- become Totally Disabled while insured for Member Life Insurance; and

- become Totally Disabled before the earlier of retirement or age 60; and

- remain Totally Disabled continuously; and

- be under the regular care and attendance of a Physician; and

- send proof of Total Disability to Us within one year of the date Total Disability starts and as often thereafter as We may require; and

- return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, We will refund premiums paid, less dividends and less any outstanding policy loan balance; and

- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician).

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

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

- the date of your death.

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

Coverage During Disability will cease on the earliest of:

- the date you are age 70; or

- the date you no longer qualify

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

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

Accelerated Benefit

An Accelerated Benefit is an advance (before death) payment of a part of your Member Life

Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for a Member Life Insurance benefit of at least $10,000; and
- be Terminally Ill (expected to die within 12 months); and
- send a request for Accelerated Benefit payment to Us; and
- send proof, satisfactory to Us, of your Terminal Illness

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

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

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

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

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

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

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

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

- Accelerated Benefit payment; plus

- Accumulated Interest Charges.

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

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

BENEFIT EXAMPLE	
Member Life Insurance Benefit Amount	$100,000
Accelerated Benefit Amount Requested (Member would receive $75,000)	$75,000
Accelerated Benefit paid on August 15 Member death occurs on November 15 (92 days after payment)	
Accumulated Interest Charges ($75,000 x .08) x (92 days/365 days)	$1512
Payment to Member's Beneficiary ($100,000 - $75,000 - $1,512)	$23,488

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

- termination of Active Work because of your Terminal Illness will not result in termination of your Member Life Insurance; and

- your Member Life Insurance will be provided without premium charge.

Individual Purchase Rights

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

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

- If the Group Policy terminates or is amended to exclude your insurance class after you have been insured for at least five years. In these instances, the maximum

amount you may buy will be the smaller of: (1) $10,000; or (2) your Member Life Insurance amount in force on the date of termination, less any Accelerated Benefit payment and Accumulated Interest Charges as discussed earlier in this Section and less any amount for which you become eligible under any group policy within 31 days.

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

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

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

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

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

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

DESCRIPTION OF BENEFITS

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefit Qualification

To qualify for benefit payment, all of the following must occur:

- You must be injured while insured for Member Accidental Death and Dismemberment Insurance.
- Your injury must be through external, violent, and accidental means.
- Your injury must be the direct and sole cause of a loss listed in Benefit Payable below.
- Your loss must occur within 365 days of your injury.
- You must satisfy the requirements listed in the CLAIM PROCEDURES Section.
- All medical evidence must be satisfactory to Us.

Benefit Payable

If all of the above qualifications are met, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force:

- 50% if one hand is severed at or above the wrist; or
- 50% if one foot is severed at or above the ankle; or
- 50% if the sight of one eye is permanently lost (For this purpose, vision not correctable to better than 20/200 will be considered loss of sight.); or
- 100% if more than one of the listed losses occurs; or
- 100% if you lose your life.

Total payment for all losses that result from the same accident will not exceed 100% of your Scheduled Benefit. Payment for loss of life will be to the beneficiary you named for Member Life Insurance. Payment for all other losses will be to you.

Disappearance

It will be presumed that you have lost your life if:

- your body has not been found within 365 days after the disappearance of a conveyance in which you were an occupant at the time of disappearance; and

- the disappearance of the conveyance was due to its accidental wrecking or sinking; and

- the Group Policy would have covered the injury resulting from the accident.

Exposure

Exposure to the elements will be presumed to be an injury if:

- such exposure is due to an accidental bodily injury; and

- within 365 days after the injury, you incur a loss that is the result of the exposure; and

- the Group Policy would have covered the injury resulting from the accident.

Seat Belt Benefit

If you lose your life as a result of an accidental injury sustained while driving or riding in an Automobile, an additional benefit of $10,000 will be paid to your beneficiary named for Member Life Insurance, provided all Benefit Qualifications as described above are met and:

- the Automobile is equipped with factory installed Seat Belts; and

- the Seat Belt was in actual use by you and properly fastened at the time of the accident; and

- the position of the Seat Belt is certified in the official report of the accident or by the investigating officer.

This additional benefit payment will also apply if you were driving an Automobile equipped with a proper functioning air bag, although your Seat Belt may not have been fastened at the time of the accident. The proper functioning and/or deployment of the air bag must be certified in the official report of the accident or by the investigating officer.

For the purpose of this benefit "Automobile" means a four-wheel passenger vehicle, station wagon, pick-up truck, or van-type vehicle, but excludes recreational type vehicles such as a "dune-buggy" or an "all-terrain" vehicle.

The term "Seat Belt" means a factory installed device that forms an occupant restraint and injury avoidance system.

Loss of Use or Paralysis Benefit

If you sustain an injury, and as a result of such injury, one or more of the covered losses

listed below are incurred, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force, provided all Benefit Qualifications as described in your booklet-certificate are met.

	Covered Loss	% of Scheduled Benefit
Loss of Use or Paralysis	Quadriplegia	100%
	Paraplegia	50%
	Hemiplegia	50%
	Both Hands or Both Feet	50%
	One Hand and One Foot	50%
	One Arm or One Leg	25%
	One Hand or One Foot	25%

We will not pay an Accidental Death and Dismemberment benefit for any paralysis caused by a stroke.

Paralysis must be determined by a Physician to be permanent, complete and irreversible.

Total payment for all losses that result from the same accident will not exceed 100% of your Scheduled Benefit (or approved amount, if applicable). Payment for loss will be to you.

For this benefit, the term "Loss of Use" means a total and irrevocable loss of voluntary movement which has continued for 12 consecutive months. The term "Quadriplegia" means total paralysis of all four limbs. The term "Paraplegia" means total paralysis of both lower limbs. The term "Hemiplegia" means paralysis of one arm and one leg on the same side of the body.

Loss of Speech and/or Hearing Benefit

If you sustain an injury, and as a result of such injury, one or more of the covered losses listed below are incurred, We will pay the following percentages of your Scheduled Benefit (or approved amount, if applicable) in force, provided all Benefit Qualifications as described in your booklet-certificate are met.

	Covered Loss	% of Scheduled Benefit
Loss of Speech and/or Hearing	Speech and Hearing	100%
	Speech or Hearing	50%

Hearing in One Ear	25%

Loss must be determined by a Physician to be permanent, complete and irreversible.

Total payment for all losses that result from the same accident will not exceed 100% of your Scheduled Benefit (or approved amount, if applicable). Payment for Loss will be to you.

For this benefit, the term "Loss" means a total and irrevocable loss of speech or hearing which has continued for 12 consecutive months.

Public Transportation Benefit

An additional benefit will be paid equal to 100% of the Scheduled Benefit amount paid under Benefits Payable, if your loss is sustained while you were a passenger in a Common Carrier which is licensed to transport people.

For this benefit, the term "Common Carrier" means airplanes, ships, trains, subways, buses, taxis or trolleys.

Repatriation Benefit

If a benefit is to be paid under this plan for loss of your life and death occurs at least 100 miles away from your permanent place of residence, all customary and reasonable expenses incurred for preparation of your body and its transportation to the place of burial or cremation will be paid up to a maximum benefit payment of $2,000.

Educational Benefit

If a benefit is to be paid under this plan for loss of your life, an extra benefit of $3,000 will be paid annually for a maximum of 4 years to each Qualified Student. This annual benefit will be paid consecutively, while the Qualified Student continues his or her education as a Full-Time Student at an accredited post-secondary school.

For this benefit, "Qualified Student" means your Dependent Child who is, at the time of your death, a Full-Time Student at an accredited post-secondary school. A 12th grade student will become a Qualified Student if he or she enrolls in an accredited post-secondary school within 12 months of your death.

Limitations

Payment will not be made for any loss to which a contributing cause is:

- willful self-injury or self-destruction, while sane or insane; or
- disease or the treatment of disease; or
- voluntary participation in a riot, assault, felony, criminal activity, or insurrection;

or

- participation in flying, ballooning, parachuting, parasailing, bungee jumping, or other aeronautic activities, except as a passenger on a commercial aircraft or as a passenger or crew member in a Policyholder-owned or leased aircraft on company business; or

- duty as a member of a military organization; or

- war or act of war; or

- the use of alcohol if, at the time of the injury, your blood alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or

- the operation by you of a motor vehicle or motor boat if, at the time of the injury, your blood alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or

- the use of any drug, narcotic, or hallucinogen not prescribed for you by a licensed Physician.

CLAIM PROCEDURES

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Payment, Denial, and Review

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

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

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

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

Medical Examinations

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

Legal Action

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

Time Limits

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

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

STATEMENT OF RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. See GH 451, if applicable**,** for further information concerning preexisting condition exclusions.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

DEFINITIONS

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

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

Basic Annual Compensation means, on any date, your basic annual (or annual equivalent) wage then in force, as established by the Policyholder. Basic wage does not include commissions, bonuses, tips, or overtime pay.

Dependent Child; Dependent Children means:

- Your natural or legally adopted child, if that child:
    - is not married; and
    - is not in the Armed Forces of any country; and
    - is not insured under the Group Policy as a Member; and
    - is less than 19 years of age.
- Your stepchild, if that child:
    - meets the requirements above; and
    - receives principal support from you.
- Your foster child, if that child:
    - meets the requirements above; and
    - lives with you; and
    - receives principal support from you; and
    - is approved in writing by Us as a Dependent Child.
- Your child 19 years but less than 25 years of age who otherwise qualifies above, if that child receives principal support from you and is a Full-Time Student, as defined.

Full Time Employee means any person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

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

- attends school on a full-time basis, as determined by the school's criteria; and

- is dependent on you for principal support.

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

Insurance Month means calendar month.

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

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

Policyholder means FISHEYE SOFTWARE, INCORPORATED.

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

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

Total Disability; Totally Disabled means for you, your inability, as determined by Us, due to sickness or injury, to perform the majority of the material duties of any occupation for which you are or may reasonably become qualified based on education, training or experience.

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

BOOKLET-CERTIFICATE RIDER

Subject: Employee Retirement Income Security Act (ERISA) Claims Procedures for Life, STD and LTD Insurance (Effective January 1, 2002)

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

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

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

CLAIM PROCEDURES

Notice of Claim

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

Claim Forms

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

Proof of Loss

For Life Insurance booklet-certificates

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

For STD and LTD Insurance policies

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

Payment, Denial, and Review

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

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

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

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

Legal Action

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

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

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

PRINCIPAL LIFE INSURANCE COMPANY
DES MOINES, IOWA 50392-0302

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PLAN ARRANGED BY

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