

SERFF Tracking Number: ICCI-126233452 State: Arkansas
 Filing Company: Virginia Surety Company, Inc. State Tracking Number: 42931
 Company Tracking Number: EM-COI (12.08) A&H
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: Group Emergency Medical filing EM-COI (12.08) A&H
 Project Name/Number: Group Emergency Medical filing EM-COI (12.08) A&H/Group Emergency Medical filing EM-COI (12.08) A&H

Filing at a Glance

Company: Virginia Surety Company, Inc.

Product Name: Group Emergency Medical filing SERFF Tr Num: ICCI-126233452 State: ArkansasLH
 EM-COI (12.08) A&H

TOI: H02G Group Health - Accident Only	SERFF Status: Closed	State Tr Num: 42931
Sub-TOI: H02G.000 Health - Accident Only	Co Tr Num: EM-COI (12.08) A&H	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Brenda Dawson	Disposition Date: 07/23/2009
	Date Submitted: 07/17/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group Emergency Medical filing EM-COI (12.08) A&H	Status of Filing in Domicile:
Project Number: Group Emergency Medical filing EM-COI (12.08) A&H	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/23/2009	Explanation for Other Group Market Type:
	State Status Changed: 07/23/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Enclosed for review and approval for use in your state are the forms attached to the Form Schedule tab. These forms are new and are not intended to replace any forms previously approved by your Department.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Virginia Surety Company, Inc. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc., at the address shown above.

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Group Policy form GEN-MAH-GP (12.08) is a Group Policy that will be issued to eligible groups in your state. GP-MAH-COI (12.08) contains the general provisions that are to be used with the Group Policy.

Certificate of Insurance form EM-MEMF-COI (12.08) (for family coverage) and Certificate of Insurance EM-MEMI-COI (12.08) (for individual member coverage) will be issued to members of eligible groups in your state, under the Group Policy. Group Schedule of Coverage EM-SOC (12.08) will be attached to the Certificates of Insurance issued in your state. Amendatory Endorsement END-AR (9.08) will be attached to all certificates issued in Arkansas.

Certificate of Insurance form EM-PAKF-COI (12.08) (for family coverage) and Certificate of Insurance form EM-PAKI-COI (9.08) (for individual member coverage) are forms similar to the Certificates described above with slight differences which reflect varying methods of distribution. They will also be issued to members of eligible groups in your state under the Group Policy. Group Schedule of Coverage ADR-PAK-SOC (9.08) will be attached to the Certificates of Insurance issued in your state. Amendatory Endorsement END-AR (9.08) will be attached to all certificates issued in Arkansas.

The Certificates of Insurance provide Emergency Medical Insurance for accidents only.

The documents were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style, formatting and/or page spacing changes. However, there will not be any changes to the actual text of the contract other than listed or bracketed variables, or to the general print size.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions.

Company and Contact

Filing Contact Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Brenda Dawson, Authorized Representative Brendadawson@inscompliance.com
3925 East State Street, Suite 200 (815) 316-6714 [Phone]
Rockford, IL 61108 (815) 986-2355[FAX]

Filing Company Information

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Virginia Surety Company, Inc. CoCode: 40827 State of Domicile: Illinois
175 West Jackson Blvd, 11th Floor Group Code: Company Type:
Chicago, IL 60604 Group Name: State ID Number:
(312) 356-3000 ext. [Phone] FEIN Number: 36-3186541

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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Virginia Surety Company, Inc.	\$50.00	07/17/2009	29277265

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/23/2009	07/23/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	07/21/2009	07/21/2009	Brenda Dawson	07/23/2009	07/23/2009

SERFF Tracking Number: *ICCI-126233452* *State:* *Arkansas*
Filing Company: *Virginia Surety Company, Inc.* *State Tracking Number:* *42931*
Company Tracking Number: *EM-COI (12.08) A&H*
TOI: *H02G Group Health - Accident Only* *Sub-TOI:* *H02G.000 Health - Accident Only*
Product Name: *Group Emergency Medical filing EM-COI (12.08) A&H*
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Disposition

Disposition Date: 07/23/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Rate and Rule Manual	Approved-Closed	No
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Supporting Document	Rate Justidication	Approved-Closed	No
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Certificate of Insurance	Approved-Closed	Yes
Form	Certificate of Insurance	Approved-Closed	Yes
Form	Certificate of Insurance	Approved-Closed	Yes
Form	Certificate of Insurance	Approved-Closed	Yes
Form	Schedule of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 07/21/2009

Submitted Date 07/21/2009

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Schedule of Coverage (Form)

Comment:

Please provide us with the dollar limits per loss.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 07/23/2009

Submitted Date 07/23/2009

Dear Rosalind Minor,

Comments:

Thank you for your letter.

Response 1

Comments: Please find attached the Rate and Rule Manual, Actuarial Memorandum, Rate justification and Statement of Variability.

Related Objection 1

Applies To:

- Schedule of Coverage (Form)

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Comment:

Please provide us with the dollar limits per loss.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Rate and Rule Manual

Comment:

Satisfied -Name: Actuarial Memorandum

Comment:

Satisfied -Name: Rate Justidication

Comment:

Satisfied -Name: Statement of Variability

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Your continued review for approval is greatly appreciated. Thank you.

Sincerely,
Brenda Dawson

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Form Schedule

Lead Form Number: EM-MEMF-COI (12.08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GEN-MAH-GP (12.08)	Policy/Cont ract/Fraternal Certificate	Group Policy	Initial		0	GEN-MAH-GP (12.08).pdf
Approved-Closed	GP-MAH-COI (12.08)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	General Provisions	Initial		0	GP-MAH-COI (12.08).pdf
Approved-Closed	EM-MEMF-COI (12.08)	Certificate	Certificate of Insurance	Initial		0	EM-MEMF-COI (12.08).pdf
Approved-Closed	EM-MEMI-COI (12.08)	Certificate	Certificate of Insurance	Initial		0	EM-MEMI-COI (12.08).pdf
Approved-Closed	EM-PAKF-COI (12.08)	Certificate	Certificate of Insurance	Initial		0	EM-PAKF-COI (12.08).pdf
Approved-Closed	EM-PAKI-COI (12.08)	Certificate	Certificate of Insurance	Initial		0	EM-PAKI-COI (12.08).pdf
Approved-Closed	EM-SOC (12.08)	Schedule Pages	Schedule of Coverage	Initial		0	EM-SOC (12.08).pdf
Approved-Closed	GP-AH-APP (12.08)	Application/ Enrollment Form	Application	Initial		0	GP-AH-APP (12 08) 5-27-09.pdf
Approved-Closed	END-AR (9.08)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendatory Endorsement	Initial			AR END-AR _9.08_.pdf

Virginia Surety Company, Inc.
A Stock Company
175 West Jackson Blvd, Chicago, Illinois 60604

GROUP POLICY
(hereinafter referred to as Policy)

PLEASE READ THIS POLICY CAREFULLY

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Policy Number: [Insert Policy Number]
Policyholder: [Insert Name and Address]
Policy Effective Date: [Insert Date], 12:01 a.m.
Policy Expiration Date: [Insert Date], 12:01 a.m.

This Policy is a legal contract between the Company and the Policyholder.

Subject to the terms of this Policy, We agree to insure Eligible Persons of the Policyholder.

A. CONSIDERATION:

The coverage listed as well as the description of the Eligible Persons on the Schedule of Coverage(s) are provided for these designated Eligible Persons of the Policyholder, subject to the terms and conditions of this Policy and the attached Certificate of Insurance. In return, the Policyholder agrees to pay the required premium when due to the Company.

B. POLICY TERM:

This Policy becomes effective on the Policy Effective Date and expires on the Policy Expiration Date shown above. This Policy shall automatically renew continuously for successive [Insert Months] month terms upon expiration unless canceled or non-renewed by the Company or Policyholder, pursuant to the provisions set forth in the termination provision. Renewal dates will hereinafter be referred to as Policy Anniversary Date. Each Policy Term begins and ends at 12:01 A.M. standard time, at the Policyholder's address listed above.

C. DEFINITIONS:

Company, We, Us, or Our means Virginia Surety Company, Inc., 175 West Jackson Blvd., Chicago, Illinois 60604.

Eligible Person means a person enrolled by the Policyholder as reflected in the Policyholder's records and for whom the required premium when due has been paid to the Company.

Policyholder means the entity that this Policy is issued to.

D. INSURING PROVISIONS:

Individual Certificate of Insurance: Certificate of Insurance, stating the terms of the insurance, will be provided to each Eligible Person by the Policyholder. Only coverage offered by the Company and listed on the Schedule of Coverage(s) and selected by the Policyholder are covered under this Policy.

Effective Date of Eligible Person's Coverage: An Eligible Person's coverage will be effective after the waiting period as selected on the Schedule of Coverage(s) from the date the Policyholder receives the request for enrollment.

Expiration Date of Eligible Person's Coverage: An Eligible Person's coverage will end on the date the Eligible Person is no longer enrolled for coverage, or when this Policy is cancelled or non-renewed by the Policyholder or Us, provided, however, that the foregoing shall not preclude a claim from being covered under this Policy if such claim relates to an event which occurred during a period for which premium has already been paid to the Company, provided there is compliance with all other terms, conditions, and exclusions of this Policy.

E. PREMIUMS:

Premium Rates: Rates for the insurance provided by this Policy are shown in the Schedule of Coverage and are subject to the Premium Change provision contained below in this Policy.

Payment of Premium: Premium must be paid to the Company within [\[Insert Payment Terms\]](#) days from the Eligible Person's acceptance into the program.

Premium Change: The Company will provide the Policyholder with at least [\[Insert Notification Period\]](#) days prior written notice of an increase or decrease to the premium for insurance provided under this Policy. Any increase or decrease in premium shall apply to Eligible Persons after the effective date indicated in written notice provided by Company.

F. ADDITIONAL PROVISIONS:

Records; Information To Be Furnished: The Policyholder will maintain records showing the essential particulars of this insurance applying to each Eligible Person and must be furnished monthly on forms acceptable to Us. The Company will be permitted to examine the Policyholder records relating to this Policy. The Company may do this at any time during the Policy Term and within two (2) years after expiration of this Policy or until final adjustment and settlement of all claims under this Policy have been made, whichever is later.

Advertising Approval: The Policyholder and its subscribing organizations will gain the prior written approval of the Company for all advertising material, including but not limited to, direct mail, printed materials, electronic media and telemarketing scripts relating to this Policy. The Company shall be reimbursed by the Policyholder for any losses resulting from advertising material that has mis-represented the coverage and that has not prior to its use been approved by the Company.

Cancellation of this Policy:

1. The Policyholder may cancel this Policy for any reason by mailing or delivering to the Company or its authorized representative written notice of cancellation at least sixty (60) days before the effective date of cancellation.
2. The Company may cancel this Policy by mailing or delivering to the Policyholder written notice of cancellation at least:
 - a. If cancelled within sixty (60) days of the Policy Effective Date:
 - i. ten (10) days before the effective date of cancellation if the Company cancels for nonpayment of premium; or
 - ii. thirty (30) days before the effective date if the Company cancels for any other reason.
 - b. If cancelled after this Policy has been in effect for sixty (60) days or more:
 - i. ten (10) days before the effective date of cancellation if the Company cancels for nonpayment of premium; or

- ii. sixty (60) days before the effective date if the Company cancels for any of the following reasons:
 - (1) The Policyholder induced issuance of this Policy through material misrepresentation;
 - (2) The Policyholder violates any of the terms and conditions of this Policy;
 - (3) Increase in risk;
 - (4) If the Company loses part or all of the reinsurance on the risk;
 - (5) If the insurance commissioner determines that to continue this Policy could place the Company in violation of the state insurance code.
3. The Company will mail or deliver the notice to the Policyholder's last mailing address known to the Company.
4. Notice of cancellation will state the effective date of cancellation. The Policy Term will end on that date. All provisions, terms and conditions of this Policy will continue to apply for any Eligible Person whose Certificate of Insurance has an Effective Date that is after the Policy Effective Date and prior to the cancellation date of this Policy for the period premium was paid.
5. If this Policy is cancelled, the Company will send the Policyholder any premium refund due. Refunds will be calculated on a pro-rata basis. The cancellation will be effective even if the Company has not made or offered a refund.

Non-renewal of this Policy: This Policy may be non-renewed as of any Policy Anniversary Date by the Company mailing to the Policyholder, by certified mail, at the last address known by the Company, written notice stating when, not less than thirty (30) days, such nonrenewal will be effective.

Conditional Renewal of this Policy: The Company has the right to conditionally renew this Policy effective on any Policy Anniversary Date based upon a change in limits, change in type of coverage, reduction of coverage, increased deductible, or upon increased premiums in excess of ten percent (exclusive of any premium increase generated as a result of increased exposure units). Notice of conditional renewal shall be treated as an effective notice of nonrenewal if such requirements are not satisfied as of the later of the Policy Expiration Date or sixty (60) days after mailing or delivery of such notice. All notices of conditional renewal will be mailed to the Policyholder at the last mailing address known to the Company, at least sixty (60) days prior to the effective date of conditional renewal and shall provide a specific explanation of the reasons for conditional renewal.

Notice to Eligible Person: If this Policy is cancelled or non-renewed, the Policyholder will provide all Eligible Person with cancellation or nonrenewal notice as required by applicable law.

Policy Change: This Policy contains all agreements between the Policyholder and Us. No agent may alter this Policy. Changes in this Policy can only be made by a filed endorsement to this Policy issued by Us.

No Benefit to Others: This coverage will in no way inure directly or indirectly to the benefit of any insurer, person, organization or other bailee.

Conformity of Statute: Terms of this Policy, which are in conflict with the statutes of the state in which it is issued, are automatically changed to conform to minimum requirements of such statutes.

Coverage and Individual Provisions: The coverage and provisions of this Policy with respect to the Eligible Person are contained in the Certificate of Insurance. A copy of the Certificate of Insurance is attached to and made a part of this Policy.

Schedule of Coverage: A copy of the Schedule of Coverage is attached to and made a part of this Policy.

This Policy is signed on Our behalf by Our Secretary and President.

[Insert Secretary Name]
Secretary

[Insert President Name]
President

Virginia Surety Company, Inc.
A Stock Company
175 W. Jackson Blvd., Chicago, IL 60604

General Provisions

This General Provisions is attached to the **COI** and is provided under a Group Policy issued to [\[Insert Policyholder\]](#), the Policyholder, by Virginia Surety Company, Inc. **Program** benefits are subject to the terms and conditions outlined in the **COI** and include certain restrictions, limitations, and exclusions. In the event of any conflict between the **COI** and the Group Policy, the Group Policy will govern. The Group Policy is on file at the offices of the **Administrator**. The **COI** shall be interpreted and enforced according to the laws of the state of Illinois.

Assignment of Benefits: All benefits will be paid to You unless You authorize Us in writing to make payment to the medical services provider.

Cancellation and Non-Renewal:

- a) Coverage can be cancelled by Us or Our designated representative for the following reasons:
 - i. Non payment of premium;
 - ii. Misrepresentation and Fraud (see below);
 - iii. The Department of Insurance determines that the **COI** would result in a violation of their law.If we cancel coverage, the Policyholder will send You written notification at least ten (10) days in advance of cancellation for non-payment of premium and at least sixty (60) days in advance of cancellation for any other reason.
- b) Coverage can be cancelled by the Policyholder at any time. If this happens, the Policyholder will send You written notification at least sixty (60) days in advance of the expiration of this coverage. Such notices need not be given if substantially similar replacement coverage takes effect without interruption and is provided by VSC. Coverage will continue to be in force for the period for which premium has already been paid to VSC.
- c) Coverage can be non-renewed by Us. The Policyholder will send You written notification at least thirty (30) days in advance of the expiration of coverage.

Claims: Benefits payable under the **COI** for any loss will be paid upon receipt of due proof of loss and all required information necessary to support the claim.

All benefits will be payable to You or, in the case of death, to Your estate. If any benefits are payable to Your estate, We may pay such benefit up to \$1,000 to any of Your relatives by blood or marriage who We deem to be equitably entitled. Any equitable payment made in good faith will release Us from liability to the extent of payment.

Dispute Resolution – Arbitration: The **COI** requires binding arbitration if there is an unresolved dispute between You and VSC concerning the **COI** (including the cost of, lack of, or actual repair or replacement arising from a loss). Under this Arbitration provision, You give up your right to resolve any dispute arising from the **COI** by a judge and/or a jury. You also agree not to participate as a class representative or class member in any class action litigation, any class arbitration or any consolidation of individual arbitrations. In arbitration, a group of three (3) arbitrators (each of whom is an independent, neutral third party) will give a decision after hearing Your and Our positions. The decision of a majority of the arbitrators will determine the outcome of the arbitration and the decision of the arbitrators shall be final and binding and cannot be reviewed or changed by, or appealed to, a court of law.

To start arbitration, either You or VSC must make a written demand to the other party for arbitration. This demand must be made within one (1) year of the earlier of the date the loss occurred or the dispute arose. You and VSC will each separately select an arbitrator. The two arbitrators will select a third arbitrator called an "umpire." Each party will each pay the expense of the arbitrator selected by that party. The expense of the umpire will be shared equally by You and VSC. Unless otherwise agreed to by You and VSC, the arbitration will take place in the county and state in which You live. The arbitration shall be governed by the Federal Arbitration Act (9 U.S.C.A. § 1 et. seq.) and not by any state law concerning arbitration. The rules of the American Arbitration Association (www.adr.org) will apply to any arbitration under the **COI**. The laws of the state of Illinois (without giving effect to its conflict of law principles) govern all matters arising out of or relating to the **COI** and all transactions contemplated by the **COI**, including, without limitation, the validity, interpretation, construction, performance and enforcement of the **COI**.

Legal Actions: No action at law or in equity shall be brought to recover under the **COI** prior to the expiration of sixty (60) days after proof of loss has been furnished in accordance with the requirements of this coverage.

Misrepresentation and Fraud: Coverage may be cancelled if, whether before or after a loss, any party or person whom coverage is provided has concealed or misrepresented any material fact or circumstance concerning this coverage or the subject thereof, or the interests therein. Coverage may also be cancelled if fraud or false is committed swearing in connection with any of the above.

Other Insurance: Coverage is secondary to any other applicable insurance or indemnity available to any party or person whom coverage is provided. Coverage is limited to only those amounts not covered by any other insurance or indemnity. In no event will this coverage apply as contributing insurance. This Other Insurance clause will take precedence over a similar clause found in other insurance or indemnity language.

Subrogation: If payment is made under the **COI**, We are entitled to recover such amounts from other parties or persons. Any party or person to or for whom We make payment must transfer to Us his or her rights to recovery against any other party or person and must do everything necessary to secure these rights and must do nothing that would jeopardize them, or these rights will be recovered from that person.

Virginia Surety Company, Inc.
A Stock Company
175 West Jackson Blvd., Chicago, Illinois 60604

[Emergency Medical]
Certificate of Insurance

This is Accident Only Coverage.

PLEASE READ THIS COI AND ATTACHED GENERAL PROVISIONS CAREFULLY

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Coverage under this **COI** and the attached General Provisions are provided under a Group Policy issued by Virginia Surety Company, Inc. This **COI** and the attached General Provisions are governed by the conditions, limitations, and exclusions of the Group Policy. This **COI** and the attached General Provisions is a legal contract between You and Virginia Surety Company, Inc.

A. DEFINITIONS

Throughout this document, “You” and “Your” refer to the person who is a member in the **Program**. Membership must not have expired or been canceled by You the **Program**. “We”, “Us”, and “VSC” refer to Virginia Surety Company, Inc. In addition, when in bold certain words and phrases are defined as follows:

Accident means an unintentional and unexpected event.

Administrator means [Insert Administrator Name]. You may contact the **Administrator** if You have questions regarding this coverage or would like to make a claim. The **Administrator** can be reached by [phone at [Insert Administrator Phone Number]] [or] [mail at [Insert Administrator Address]] [or] [email at [Insert Administrator e-mail Address]].

[**Auto Related Accident** means an **Accident** which occurs:

- 1) While as a pedestrian, You or Your **Family Member** are struck by a **Private Passenger Automobile**.
- 2) While You or Your **Family Member** are riding in, entering, or exiting a **Private Passenger Automobile** (excluding an automobile used for a commercial purpose.)

Certificate of Insurance (COI) means this document and the attached General Provisions. They describe the terms, conditions, and exclusions. This **COI** and the attached General Provisions are the entire agreement between You and Us. Representations or promises made by anyone that are not contained in this **COI** and the attached General Provisions are not a part of Your coverage.

Coverage Period means the period starting on the **Membership Effective Date** and will continue [for [Insert Program Term]] [monthly].

[**Covered Health Deductible** means the amount of the deductible in Your or Your **Family Member’s** health insurance coverage (including, but not limited to, a PPO or HMO), that You or Your **Family Member** are required to pay.]

Covered Individual means Your **Family Member** [and includes a **Home Visitor** in a **Home Related Accident**].

Domestic Partner means an unmarried person in an intimate, committed relationship of mutual caring. That person must share responsibility for basic living expenses with You. That person must also be at least eighteen (18) years old and not currently married or committed to another person.

[Emergency Treatment Expenses means the charge You or a **Covered Individual** are required to pay for **Outpatient Treatment** at a **Medical Facility** for:

- 1) Diagnosis, treatment or surgery performed by a **Physician, Surgeon, or Dentist**.
- 2) Laboratory tests and X-ray exams that are made by or at the request of the **Physician, Surgeon, or Dentist**.
- 3) Casts, splints and medication.
- 4) Any other reasonable and necessary emergency services and supplies.]

Family Member means Your spouse or **Domestic Partner**. **Family Member** also includes Your or Your spouse or Domestic Partner's:

- a) Unmarried children (including those who You are their legal guardian) under twenty-one (21) years of age.
- b) Unmarried children (including those who You are their legal guardian) under twenty-three (23) years of age if a full-time student at an accredited college or university.
- c) Any dependent with documented disabilities who has the same **Home** as You and who relies on You for maintenance and support.

Any **Family Member** who does not reside at Your **Home** is not eligible for coverage.

[Home means either a single-family dwelling or a multiple-family dwelling (e.g. condominium, townhome, mobile home on a permanent foundation, or apartment unit) that is normally inhabited by You.]

[Home Related Accident means an **Accident** which occurs at Your **Home**.]

[Home Visitor means a person visiting You or Your **Family Member** who does not reside at Your **Home**.]

Injury means bodily injury resulting from an **Accident** that occurs during the **Coverage Period**.

[Inpatient Treatment means treatment that takes place in a controlled environment that requires being admitted into a **Medical Facility** for a period of time of at least twenty-four (24) hours.]

[Medical Facility means a hospital, walk-in medical center, or outpatient clinic which meets all of the following requirements:

- 1) Is licensed by a state, federal, or provincial regulatory entity.
- 2) Is operated primarily for the reception, care, and treatment of sick, ailing or injured persons.
- 3) Has a staff of one or more licensed **Physicians** available at all times when patients are present.
- 4) Provides facilities for diagnosis and surgery.

Medical Facility does not include nursing, rest, or convalescent homes.]

Membership Effective Date means the date You enroll as a member in the **Program** or upon receipt of payment of Your initial membership dues as per the membership terms and conditions for the **Program**, whichever occurs last.

[Outpatient Treatment means treatment that takes place in a controlled environment that does not require being admitted into a **Medical Facility** for a period of time more than twenty-four (24) hours.]

Physician, Surgeon, or Dentist means a licensed or certified practitioner of the healing arts. The **Physician, Surgeon, or Dentist** must perform a covered service within the scope of the practitioner's license or certificate. The treating **Physician, Surgeon, or Dentist** may not be You, a **Covered Individual**, or related to You or a **Covered Individual**.

[Private Passenger Automobile means a vehicle designed and licensed for use on public roads. **Private Passenger Automobiles** include private passenger cars, station wagons, jeep-type vehicles, SUV's, trucks, and pick-ups. **Private Passenger Automobile** does not include motor homes, RVs campers, trailers, ATVs, motorcycles, or vehicles designed to seat more than eight (8) passengers.]

Program means [\[Insert Program\]](#).

B. COVERAGES

You or a **Covered Individual** may only receive coverage for the same expenses under one of the following benefits.

1. **EMERGENCY MEDICAL EXPENSE BENEFIT**

We will reimburse You for **Emergency Treatment Expenses** (for **Outpatient Treatment**), if You or a **Covered Individual** require emergency treatment in a **Medical Facility** as a result of an **Injury** received in [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The emergency treatment must be received within forty-eight (48) hours after the **Accident**.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

2. **AMBULANCE AND PARAMEDIC EXPENSE BENEFIT**

We will reimburse You for ambulance and/or paramedic expenses incurred, if You or a **Covered Individual** require ambulance transportation and/or paramedic service as the result of an **Injury** caused by [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The ambulance service transportation must be furnished by a licensed ambulance provider within forty-eight hours of the **Accident** and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) Expenses for ambulance transportation and/or paramedic service actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

3. **HEALTH INSURANCE DEDUCTIBLE REIMBURSEMENT BENEFIT**

We will reimburse You the **Covered Health Deductible** on Your or Your **Family Member's** health insurance coverage, if You or Your **Family Member** receive [Outpatient Treatment] [or] [Inpatient Treatment] as a result of the **Injury**.

To be eligible for coverage:

- 1) You or Your **Family Member** must be insured by health insurance coverage.
- 2) You or a **Family Member** must have submitted a claim which was paid by Your or Your **Family Member's** health insurance company which included a **Covered Health Deductible**.

Coverage is limited to the **Covered Health Deductible** up to [Insert Dollar Limit] per **Accident**.

4. **CHILD'S ACCIDENT EXPENSE BENEFIT**

We will reimburse You for medical expenses incurred, if a child (who is a **Family Member**) suffers an **Injury** received in an **Accident** and incurs:

- 1) **Emergency Treatment Expenses** (for **Outpatient Treatment**); or
- 2) Ambulance transportation services and/or paramedic treatment within [forty-eight (48)] hours after an **Accident**. The ambulance service transportation must be furnished by a licensed ambulance provider and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred and expenses for ambulance transportation and/or paramedic services actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

C. EXCLUSIONS

The following exclusions apply to [Emergency Medical Expense Benefit] [,] [and] [Ambulance and Paramedic Expense Benefit] [,] [and] [Health Insurance Deductible Reimbursement] [,] [and] [Child's Accident Expense Benefit]:

Any loss caused by or resulting from:

- Suicide, attempted suicide, or any self-inflicted injury while sane or insane.
- War, including undeclared war; civil war; insurrection; rebellion; warlike act by military force or military personnel; destruction, seizure, or use for a military purpose, including any consequence of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental.
- Nuclear hazard, meaning any weapon employing atomic fission, fusion, or other radioactive force or nuclear reaction, radiation, or radioactive contamination from any other cause except that direct loss by fire resulting from the nuclear hazard is covered.
- Bacterial infection, except pus-forming infections resulting from **Injury**.
- Participation in or attempting to commit a felony.
- Illness, disease or allergic reaction.
- Being under the influence of narcotics, unless they are taken in accordance with the advice of a **Physician, Surgeon, or Dentist**.
- Being under the influence of any intoxicating liquor. (An intoxicating liquor is that which is defined as or determined to be such by the laws of the jurisdiction where the loss or cause of loss occurred.)
- **Injury** occurring while You or a **Covered Individual** are using Your **Home** or accompanying structures and grounds for commercial purposes.
- Any **Injury** caused by or resulting from operating, riding in, entering or exiting any vehicle which is (a) being tested or time tested; or (b) participating in races, speed contests, or exhibitions of any kind.
- An **Injury** resulting from domestic violence.
- An **Injury** that occurred outside the United States or Canada.

[[The following exclusions apply to Health Insurance Deductible Reimbursement:]]

- Any co-pays or co-insurance.
- Any **Injury** where You or Your **Family Member** are not insured under any health insurance coverage.
- Any **Injury** if the expenses incurred are not covered by Your or Your **Family Member's** health insurance coverage.]

D. HOW TO FILE A CLAIM

Call the **Administrator** at [Insert Administrator Phone Number] to request a claim form. You must report the claim within forty-five (45) days of the **Accident**.

The following required items, must sent to the **Administrator** at [Insert Administrator Address] and be postmarked within ninety (90) days of **Accident**.

1. The completed claim form.
2. Signed HIPPA authorization form from You or the **Covered Individual** (if applicable).
3. A copy of the declaration page from Your or the **Covered Individual's** health insurance company.
4. A copy of the claim from Your or the **Covered Individual's** health insurance company showing the claim was approved, with the amount paid and the deductible of the health insurance policy.
5. Any other documentation the **Administrator** may reasonably request.

Virginia Surety Company, Inc.
A Stock Company
175 West Jackson Blvd., Chicago, Illinois 60604

**[Emergency Medical]
Certificate of Insurance**

This is Accident Only Coverage.

PLEASE READ THIS COI AND ATTACHED GENERAL PROVISIONS CAREFULLY

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Coverage under this **COI** and the attached General Provisions are provided under a Group Policy issued by Virginia Surety Company, Inc. This **COI** and the attached General Provisions are governed by the conditions, limitations, and exclusions of the Group Policy. This **COI** and the attached General Provisions is a legal contract between You and Virginia Surety Company, Inc.

A. DEFINITIONS

Throughout this document, “You” and “Your” refer to the person who is a member in the **Program**. Membership must not have expired or been canceled by You the **Program**. “We”, “Us”, and “VSC” refer to Virginia Surety Company, Inc. In addition, when in bold certain words and phrases are defined as follows:

Accident means an unintentional and unexpected event.

Administrator means [Insert Administrator Name]. You may contact the **Administrator** if You have questions regarding this coverage or would like to make a claim. The **Administrator** can be reached by [phone at [Insert Administrator Phone Number]] [or] [mail at [Insert Administrator Address]] [or] [email at [Insert Administrator e-mail Address]].

[**Auto Related Accident** means an **Accident** which occurs:

- 1) While as a pedestrian, You are struck by a **Private Passenger Automobile**.
- 2) While You are riding in, entering, or exiting a **Private Passenger Automobile** (excluding an automobile used for a commercial purpose).]

Certificate of Insurance (COI) means this document and the attached General Provisions. They describe the terms, conditions, and exclusions. This **COI** and the attached General Provisions are the entire agreement between You and Us. Representations or promises made by anyone that are not contained in this **COI** and the attached General Provisions are not a part of Your coverage.

Coverage Period means the period starting on the **Membership Effective Date** and will continue [for [Insert Program Term]] [monthly].

[**Covered Health Deductible** means the amount of the deductible in Your health insurance coverage (including, but not limited to, a PPO or HMO), that You are required to pay.]

[**Emergency Treatment Expenses** means the charge You are required to pay for **Outpatient Treatment** at a **Medical Facility** for:

- 1) Diagnosis, treatment or surgery performed by a **Physician, Surgeon, or Dentist**.

- 2) Laboratory tests and X-ray exams that are made by or at the request of the **Physician, Surgeon, or Dentist.**
- 3) Casts, splints and medication.
- 4) Any other reasonable and necessary emergency services and supplies.]

[**Home** means either a single-family dwelling or a multiple-family dwelling (e.g. condominium, townhome, mobile home on a permanent foundation, or apartment unit) that is normally inhabited by You.]

[**Home Related Accident** means an **Accident** which occurs at Your **Home**.]

[**Home Visitor** means a person visiting who does not reside at Your **Home**.]

Injury means bodily injury resulting from an **Accident** that occurs during the **Coverage Period**.

[**Inpatient Treatment** means treatment that takes place in a controlled environment that requires being admitted into a **Medical Facility** for a period of time of at least twenty-four (24) hours.]

[**Medical Facility** means a hospital, walk-in medical center, or outpatient clinic which meets all of the following requirements:

- 1) Is licensed by a state, federal, or provincial regulatory entity.
- 2) Is operated primarily for the reception, care, and treatment of sick, ailing or injured persons.
- 3) Has a staff of one or more licensed **Physicians** available at all times when patients are present.
- 4) Provides facilities for diagnosis and surgery.

Medical Facility does not include nursing, rest, or convalescent homes.]

Membership Effective Date means the date You enroll as a member in the **Program** or upon receipt of payment of Your initial membership dues as per the membership terms and conditions for the **Program**, whichever occurs last.

[**Outpatient Treatment** means treatment that takes place in a controlled environment that does not require being admitted into a **Medical Facility** for a period of time more than twenty-four (24) hours.]

Physician, Surgeon, or Dentist means a licensed or certified practitioner of the healing arts. The **Physician, Surgeon, or Dentist** must perform a covered service within the scope of the practitioner's license or certificate. The treating **Physician, Surgeon, or Dentist** may not be You or related to You.

[**Private Passenger Automobile** means a vehicle designed and licensed for use on public roads. **Private Passenger Automobiles** include private passenger cars, station wagons, jeep-type vehicles, SUV's, trucks, and pick-ups. **Private Passenger Automobile** does not include motor homes, RVs campers, trailers, ATVs, motorcycles, or vehicles designed to seat more than eight (8) passengers.]

Program means [Insert Program].

B. COVERAGES

You may only receive coverage for the same expenses under one of the following benefits.

1. **EMERGENCY MEDICAL EXPENSE BENEFIT**

We will reimburse You for **Emergency Treatment Expenses** (for **Outpatient Treatment**), if You require emergency treatment in a **Medical Facility** as a result of an **Injury** received in [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The emergency treatment must be received within forty-eight (48) hours after the **Accident**.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

2. **AMBULANCE AND PARAMEDIC EXPENSE BENEFIT**

We will reimburse You for ambulance and/or paramedic expenses incurred, if You require ambulance transportation and/or paramedic service as the result of an **Injury** caused by [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The ambulance service transportation must be furnished by a licensed ambulance provider within forty-eight hours of the **Accident** and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) Expenses for ambulance transportation and/or paramedic service actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

3. **HEALTH INSURANCE DEDUCTIBLE REIMBURSEMENT BENEFIT**

We will reimburse You the **Covered Health Deductible** on Your health insurance coverage, if You receive [**Outpatient Treatment**] [or] [**Inpatient Treatment**] as a result of the **Injury**.

To be eligible for coverage:

- 1) You must be insured by health insurance coverage.
- 2) You must have submitted a claim which was paid by Your health insurance company which included a **Covered Health Deductible**.

Coverage is limited to the **Covered Health Deductible** up to [Insert Dollar Limit] per **Accident**.

C. EXCLUSIONS

The following exclusions apply to [Emergency Medical Expense Benefit] [,] [and] [Ambulance and Paramedic Expense Benefit] [,] [and] [Health Insurance Deductible Reimbursement] [,] [and] [Child's Accident Expense Benefit]:

Any loss caused by or resulting from:

- Suicide, attempted suicide, or any self-inflicted injury while sane or insane.
- War, including undeclared war; civil war; insurrection; rebellion; warlike act by military force or military personnel; destruction, seizure, or use for a military purpose, including any consequence of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental.
- Nuclear hazard, meaning any weapon employing atomic fission, fusion, or other radioactive force or nuclear reaction, radiation, or radioactive contamination from any other cause except that direct loss by fire resulting from the nuclear hazard is covered.
- Bacterial infection, except pus-forming infections resulting from **Injury**.
- Participation in or attempting to commit a felony.
- Illness, disease or allergic reaction.
- Being under the influence of narcotics, unless they are taken in accordance with the advice of a **Physician, Surgeon, or Dentist**.
- Being under the influence of any intoxicating liquor. (An intoxicating liquor is that which is defined as or determined to be such by the laws of the jurisdiction where the loss or cause of loss occurred.)
- **Injury** occurring while You are using Your **Home** or accompanying structures and grounds for commercial purposes.
- Any **Injury** caused by or resulting from operating, riding in, entering or exiting any vehicle which is (a) being tested or time tested; or (b) participating in races, speed contests, or exhibitions of any kind.
- An **Injury** resulting from domestic violence.
- An **Injury** that occurred outside the United States or Canada.

[[The following exclusions apply to Health Insurance Deductible Reimbursement:]]

- Any co-pays or co-insurance.
- Any **Injury** where You are not insured under any health insurance coverage.
- Any **Injury** if the expenses incurred are not covered by Your health insurance coverage.]

D. HOW TO FILE A CLAIM

Call the **Administrator** at [\[Insert Administrator Phone Number\]](#) to request a claim form. You must report the claim within forty-five (45) days of the **Accident**.

The following required items, must sent to the **Administrator** at [\[Insert Administrator Address\]](#) and be postmarked within ninety (90) days of **Accident**.

1. The completed claim form.
2. Signed HIPPA authorization form from You.
3. A copy of the declaration page from Your health insurance company.
4. A copy of the claim from Your health insurance company showing the claim was approved, with the amount paid and the deductible of the health insurance policy.
5. Any other documentation the **Administrator** may reasonably request.

Virginia Surety Company, Inc.
A Stock Company
175 West Jackson Blvd., Chicago, Illinois 60604

**[Emergency Medical]
Certificate of Insurance**

This is Accident Only Coverage.

PLEASE READ THIS COI AND ATTACHED GENERAL PROVISIONS CAREFULLY

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Coverage under this **COI** and the attached General Provisions are provided under a Group Policy issued by Virginia Surety Company, Inc. This **COI** and the attached General Provisions are governed by the conditions, limitations, and exclusions of the Group Policy. This **COI** and the attached General Provisions is a legal contract between You and Virginia Surety Company, Inc.

A. DEFINITIONS

Throughout this document, You and Your refer to the person who purchased the **Program**. We, Us, Our, and VSC refer to Virginia Surety Company, Inc. In addition, when in bold certain words and phrases are defined as follows:

Accident means an unintentional and unexpected event.

Administrator means [Insert Administrator Name]. You may contact the **Administrator** if You have questions regarding this coverage or would like to make a claim. The **Administrator** can be reached by [phone at [Insert Administrator Phone Number]] [or] [mail at [Insert Administrator Address]] [or] [email at [Insert Administrator e-mail Address]].

[**Auto Related Accident** means an **Accident** which occurs:

- 1) While as a pedestrian, You or Your **Family Member** are struck by a **Private Passenger Automobile**.
- 2) While You or Your **Family Member** are riding in, entering, or exiting a **Private Passenger Automobile** (excluding an automobile used for a commercial purpose).]

Certificate of Insurance (COI) means this document and the attached General Provisions. They describe the terms, conditions, and exclusions. This **COI** and the attached General Provisions are the entire agreement between You and Us. Representations or promises made by anyone that are not contained in this **COI** and the attached General Provisions are not a part of Your coverage.

Coverage Period means the period starting on the **Effective Date** and will continue [for [Insert Program Term]] [monthly].

[**Covered Health Deductible** means the amount of the deductible in Your or Your **Family Member’s** health insurance coverage (including, but not limited to, a PPO or HMO), that You or Your **Family Member** are required to pay.]

Covered Individual means Your **Family Member** [and includes a **Home Visitor** in a **Home Related Accident**].

Domestic Partner means an unmarried person in an intimate, committed relationship of mutual caring. That person must share responsibility for basic living expenses with You. That person must also be at least eighteen (18) years old and not currently married or committed to another person.

Effective Date means the date You purchased the **Program**.

[Emergency Treatment Expenses means the charge You or a **Covered Individual** are required to pay for **Outpatient Treatment** at a **Medical Facility** for:

- 1) Diagnosis, treatment or surgery performed by a **Physician, Surgeon, or Dentist**.
- 2) Laboratory tests and X-ray exams that are made by or at the request of the **Physician, Surgeon, or Dentist**.
- 3) Casts, splints and medication.
- 4) Any other reasonable and necessary emergency services and supplies.]

Family Member means Your spouse or **Domestic Partner**. **Family Member** also includes Your or Your spouse or Domestic Partner's:

- a) Unmarried children (including those who You are their legal guardian) under twenty-one (21) years of age.
- b) Unmarried children (including those who You are their legal guardian) under twenty-three (23) years of age if a full-time student at an accredited college or university.
- c) Any dependent with documented disabilities who has the same **Home** as You and who relies on You for maintenance and support.

Any **Family Member** who does not reside at Your **Home** is not eligible for coverage.

[Home means either a single-family dwelling or a multiple-family dwelling (e.g. condominium, townhome, mobile home on a permanent foundation, or apartment unit) that is normally inhabited by You.]

[Home Related Accident means an **Accident** which occurs at Your **Home**.]

[Home Visitor means a person visiting You or Your **Family Member** who does not reside at Your **Home**.]

Injury means bodily injury resulting from an **Accident** that occurs during the **Coverage Period**.

[Inpatient Treatment means treatment that takes place in a controlled environment that requires being admitted into a **Medical Facility** for a period of time of at least twenty-four (24) hours.]

[Medical Facility means a hospital, walk-in medical center, or outpatient clinic which meets all of the following requirements:

- 1) Is licensed by a state, federal, or provincial regulatory entity.
- 2) Is operated primarily for the reception, care, and treatment of sick, ailing or injured persons.
- 3) Has a staff of one or more licensed **Physicians** available at all times when patients are present.
- 4) Provides facilities for diagnosis and surgery.

Medical Facility does not include nursing, rest, or convalescent homes.]

[Outpatient Treatment means treatment that takes place in a controlled environment that does not require being admitted into a **Medical Facility** for a period of time more than twenty-four (24) hours.]

Physician, Surgeon, or Dentist means a licensed or certified practitioner of the healing arts. The **Physician, Surgeon, or Dentist** must perform a covered service within the scope of the practitioner's license or certificate. The treating **Physician, Surgeon, or Dentist** may not be You, a **Covered Individual**, or related to You or a **Covered Individual**.

[Private Passenger Automobile means a vehicle designed and licensed for use on public roads. **Private Passenger Automobiles** include private passenger cars, station wagons, jeep-type vehicles, SUV's, trucks, and pick-ups. **Private Passenger Automobile** does not include motor homes, RVs campers, trailers, ATVs, motorcycles, or vehicles designed to seat more than eight (8) passengers.]

Program means [Insert Program].

B. COVERAGES

You or a **Covered Individual** may only receive coverage for the same expenses under one of the following benefits.

1. **EMERGENCY MEDICAL EXPENSE BENEFIT**

We will reimburse You for **Emergency Treatment Expenses** (for **Outpatient Treatment**), if You or a **Covered Individual** require emergency treatment in a **Medical Facility** as a result of an **Injury** received in [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The emergency treatment must be received within forty-eight (48) hours after the **Accident**.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

2. **AMBULANCE AND PARAMEDIC EXPENSE BENEFIT**

We will reimburse You for ambulance and/or paramedic expenses incurred, if You or a **Covered Individual** require ambulance transportation and/or paramedic service as the result of an **Injury** caused by [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The ambulance service transportation must be furnished by a licensed ambulance provider within forty-eight hours of the **Accident** and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) Expenses for ambulance transportation and/or paramedic service actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

3. **HEALTH INSURANCE DEDUCTIBLE REIMBURSEMENT BENEFIT**

We will reimburse You the **Covered Health Deductible** on Your or Your **Family Member's** health insurance coverage, if You or Your **Family Member** receive [**Outpatient Treatment**] [or] [**Inpatient Treatment**] as a result of the **Injury**.

To be eligible for coverage:

- 1) You or Your **Family Member** must be insured by health insurance coverage.
- 2) You or a **Family Member** must have submitted a claim which was paid by Your or Your **Family Member's** health insurance company which included a **Covered Health Deductible**.

Coverage is limited to the **Covered Health Deductible** up to [Insert Dollar Limit] per **Accident**.

4. **CHILD'S ACCIDENT EXPENSE BENEFIT**

We will reimburse You for medical expenses incurred, if a child (who is a **Family Member**) suffers an **Injury** received in an **Accident** and incurs:

- 1) **Emergency Treatment Expenses** (for **Outpatient Treatment**); or
- 2) Ambulance transportation services and/or paramedic treatment within [forty-eight (48)] hours after an **Accident**. The ambulance service transportation must be furnished by a licensed ambulance provider and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred and expenses for ambulance transportation and/or paramedic services actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

C. EXCLUSIONS

The following exclusions apply to [Emergency Medical Expense Benefit] [,] [and] [Ambulance and Paramedic Expense Benefit] [,] [and] [Health Insurance Deductible Reimbursement] [,] [and] [Child's Accident Expense Benefit]:

Any loss caused by or resulting from:

- Suicide, attempted suicide, or any self-inflicted injury while sane or insane.
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- Nuclear hazard, meaning any weapon employing atomic fission, fusion, or other radioactive force or nuclear reaction, radiation, or radioactive contamination from any other cause except that direct loss by fire resulting from the nuclear hazard is covered.
- Bacterial infection, except pus-forming infections resulting from **Injury**.
- Participation in or attempting to commit a felony.
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- Being under the influence of narcotics, unless they are taken in accordance with the advice of a **Physician, Surgeon, or Dentist**.
- Being under the influence of any intoxicating liquor. (An intoxicating liquor is that which is defined as or determined to be such by the laws of the jurisdiction where the loss or cause of loss occurred.)
- **Injury** occurring while You or a **Covered Individual** are using Your **Home** or accompanying structures and grounds for commercial purposes.
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[[The following exclusions apply to Health Insurance Deductible Reimbursement:]]

- Any co-pays or co-insurance.
- Any **Injury** where You or Your **Family Member** are not insured under any health insurance coverage.
- Any **Injury** if the expenses incurred are not covered by Your or Your **Family Member's** health insurance coverage.]

D. HOW TO FILE A CLAIM

Call the **Administrator** at [Insert Administrator Phone Number] to request a claim form. You must report the claim within forty-five (45) days of the **Accident**.

The following required items, must sent to the **Administrator** at [Insert Administrator Address] and be postmarked within ninety (90) days of **Accident**.

1. The completed claim form.
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3. A copy of the declaration page from Your or the **Covered Individual's** health insurance company.
4. A copy of the claim from Your or the **Covered Individual's** health insurance company showing the claim was approved, with the amount paid and the deductible of the health insurance policy.
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Virginia Surety Company, Inc.
A Stock Company
175 West Jackson Blvd., Chicago, Illinois 60604

[Emergency Medical]
Certificate of Insurance

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Throughout this document, You and Your refer to the person who purchased the **Program**. We, Us, Our, and VSC refer to Virginia Surety Company, Inc. In addition, when in bold certain words and phrases are defined as follows:

Accident means an unintentional and unexpected event.

Administrator means [Insert Administrator Name]. You may contact the **Administrator** if You have questions regarding this coverage or would like to make a claim. The **Administrator** can be reached by [phone at [Insert Administrator Phone Number]] [or] [mail at [Insert Administrator Address]] [or] [email at [Insert Administrator e-mail Address]].

[**Auto Related Accident** means an **Accident** which occurs:

- 1) While as a pedestrian, You are struck by a **Private Passenger Automobile**.
- 2) While You are riding in, entering, or exiting a **Private Passenger Automobile** (excluding an automobile used for a commercial purpose).]

Certificate of Insurance (COI) means this document and the attached General Provisions. They describe the terms, conditions, and exclusions. This **COI** and the attached General Provisions are the entire agreement between You and Us. Representations or promises made by anyone that are not contained in this **COI** and the attached General Provisions are not a part of Your coverage.

Coverage Period means the period starting on the **Effective Date** and will continue [for [Insert Program Term]] [monthly].

[**Covered Health Deductible** means the amount of the deductible in Your health insurance coverage (including, but not limited to, a PPO or HMO), that You are required to pay.]

Effective Date means the date You purchased the **Program**.

[**Emergency Treatment Expenses** means the charge You are required to pay for **Outpatient Treatment** at a **Medical Facility** for:

- 1) Diagnosis, treatment or surgery performed by a **Physician, Surgeon, or Dentist.**
- 2) Laboratory tests and X-ray exams that are made by or at the request of the **Physician, Surgeon, or Dentist.**
- 3) Casts, splints and medication.
- 4) Any other reasonable and necessary emergency services and supplies.]

[**Home** means either a single-family dwelling or a multiple-family dwelling (e.g. condominium, townhome, mobile home on a permanent foundation, or apartment unit) that is normally inhabited by You.]

[**Home Related Accident** means an **Accident** which occurs at Your **Home**.]

[**Home Visitor** means a person visiting who does not reside at Your **Home**.]

Injury means bodily injury resulting from an **Accident** that occurs during the **Coverage Period**.

[**Inpatient Treatment** means treatment that takes place in a controlled environment that requires being admitted into a **Medical Facility** for a period of time of at least twenty-four (24) hours.]

[**Medical Facility** means a hospital, walk-in medical center, or outpatient clinic which meets all of the following requirements:

- 1) Is licensed by a state, federal, or provincial regulatory entity.
- 2) Is operated primarily for the reception, care, and treatment of sick, ailing or injured persons.
- 3) Has a staff of one or more licensed **Physicians** available at all times when patients are present.
- 4) Provides facilities for diagnosis and surgery.

Medical Facility does not include nursing, rest, or convalescent homes.]

[**Outpatient Treatment** means treatment that takes place in a controlled environment that does not require being admitted into a **Medical Facility** for a period of time more than twenty-four (24) hours.]

Physician, Surgeon, or Dentist means a licensed or certified practitioner of the healing arts. The **Physician, Surgeon, or Dentist** must perform a covered service within the scope of the practitioner's license or certificate. The treating **Physician, Surgeon, or Dentist** may not be You or related to You.

[**Private Passenger Automobile** means a vehicle designed and licensed for use on public roads. **Private Passenger Automobiles** include private passenger cars, station wagons, jeep-type vehicles, SUV's, trucks, and pick-ups. **Private Passenger Automobile** does not include motor homes, RVs campers, trailers, ATVs, motorcycles, or vehicles designed to seat more than eight (8) passengers.]

Program means [Insert Program].

B. COVERAGES

You may only receive coverage for the same expenses under one of the following benefits.

1. **EMERGENCY MEDICAL EXPENSE BENEFIT**

We will reimburse You for **Emergency Treatment Expenses** (for **Outpatient Treatment**), if You require emergency treatment in a **Medical Facility** as a result of an **Injury** received in [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The emergency treatment must be received within forty-eight (48) hours after the **Accident**.

Reimbursement is limited to the lesser of the following:

- 1) **Emergency Treatment Expenses** actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

2. **AMBULANCE AND PARAMEDIC EXPENSE BENEFIT**

We will reimburse You for ambulance and/or paramedic expenses incurred, if You require ambulance transportation and/or paramedic service as the result of an **Injury** caused by [a **Home Related Accident**] [or] [an **Auto Related Accident**]. The ambulance service transportation must be furnished by a licensed ambulance provider within forty-eight hours of the **Accident** and must be for urgent medical attention. The paramedic service(s) must be provided by a certified emergency medical technician.

Reimbursement is limited to the lesser of the following:

- 1) Expenses for ambulance transportation and/or paramedic service actually incurred.
- 2) [Insert Dollar Limit] per **Accident**.

3. **HEALTH INSURANCE DEDUCTIBLE REIMBURSEMENT BENEFIT**

We will reimburse You the **Covered Health Deductible** on Your health insurance coverage, if You receive [Outpatient Treatment] [or] [Inpatient Treatment] as a result of the **Injury**.

To be eligible for coverage:

- 1) You must be insured by health insurance coverage.
- 2) You must have submitted a claim which was paid by Your health insurance company which included a **Covered Health Deductible**.

Coverage is limited to the **Covered Health Deductible** up to [Insert Dollar Limit] per **Accident**.

C. EXCLUSIONS

The following exclusions apply to [Emergency Medical Expense Benefit] [,] [and] [Ambulance and Paramedic Expense Benefit] [,] [and] [Health Insurance Deductible Reimbursement] [,] [and] [Child's Accident Expense Benefit]:

Any loss caused by or resulting from:

- Suicide, attempted suicide, or any self-inflicted injury while sane or insane.
- War, including undeclared war; civil war; insurrection; rebellion; warlike act by military force or military personnel; destruction, seizure, or use for a military purpose, including any consequence of these. Discharge of a nuclear weapon shall be deemed a warlike act even if accidental.
- Nuclear hazard, meaning any weapon employing atomic fission, fusion, or other radioactive force or nuclear reaction, radiation, or radioactive contamination from any other cause except that direct loss by fire resulting from the nuclear hazard is covered.
- Bacterial infection, except pus-forming infections resulting from **Injury**.
- Participation in or attempting to commit a felony.
- Illness, disease or allergic reaction.
- Being under the influence of narcotics, unless they are taken in accordance with the advice of a **Physician, Surgeon, or Dentist**.
- Being under the influence of any intoxicating liquor. (An intoxicating liquor is that which is defined as or determined to be such by the laws of the jurisdiction where the loss or cause of loss occurred.)
- **Injury** occurring while You are using Your **Home** or accompanying structures and grounds for commercial purposes.
- Any **Injury** caused by or resulting from operating, riding in, entering or exiting any vehicle which is (a) being tested or time tested; or (b) participating in races, speed contests, or exhibitions of any kind.
- An **Injury** resulting from domestic violence.
- An **Injury** that occurred outside the United States or Canada.

[[The following exclusions apply to Health Insurance Deductible Reimbursement:]]

- Any co-pays or co-insurance.
- Any **Injury** where You are not insured under any health insurance coverage.
- Any **Injury** if the expenses incurred are not covered by Your health insurance coverage.]

D. HOW TO FILE A CLAIM

Call the **Administrator** at [Insert Administrator Phone Number] to request a claim form. You must report the claim within forty-five (45) days of the **Accident**.

The following required items, must sent to the **Administrator** at [Insert Administrator Address] and be postmarked within ninety (90) days of **Accident**.

1. The completed claim form.
2. Signed HIPPA authorization form from You.
3. A copy of the declaration page from Your health insurance company.
4. A copy of the claim from Your health insurance company showing the claim was approved, with the amount paid and the deductible of the health insurance policy.
5. Any other documentation the **Administrator** may reasonably request.

Virginia Surety Company, Inc.
A Stock Company
175 West Jackson Blvd., Chicago, Illinois 60604

SCHEDULE OF COVERAGE

Policy Number: [Insert Policy Number]
Policyholder: [Insert Policyholder Name]
Schedule Number: [Insert Schedule Number]
Schedule Effective Date: [Insert Date], 12:01 a.m.

[[Membership Name] [Program Name]: [Insert Membership/Program name]]

Coverage selected for Eligible Persons of the Policyholder:

[Emergency Medical Expense]

Coverage Plan:

[Auto Related Accident]
[Home Related Accident]

Who is Covered:

[Individual]
[Individual & Family Members]
[Individual, Family Members, & Home Visitor]

Limit Per Loss:

#[Insert Limit]

Coverage Period Options:

[[Insert Number] [Month] [Year] [s]]
[Monthly]

Premium Rate For Selected Coverage:

#[Insert Rate] per Eligible Person per [Insert Number (if applicable)] [month] [years] [s]]

[Ambulance and Paramedic Expense]

Coverage Plan:

[Auto Related Accident]
[Home Related Accident]

Who is Covered:

[Individual]
[Individual & Family Members]
[Individual, Family Members, & Home Visitor]

Limit Per Loss:

#[Insert Limit]

Coverage Period Options:

[[Insert Number] [Month] [Year] [s]]
[Monthly]

Premium Rate For Selected Coverage:

[\$[Insert Rate] per Eligible Person per [Insert Number (if applicable)] [month] [years] [s]]

[Health Insurance Deductible Reimbursement

Who is Covered:

[Individual]

[Individual & Family Members]

Limit Per Loss:

[\$[Insert Limit]

Coverage Period Options:

[[Insert Number] [Month] [Year] [s]]

[Monthly]

Premium Rate For Selected Coverage:

[\$[Insert Rate] per Eligible Person per [Insert Number (if applicable)] [month] [years] [s]]

[Child's Accident Expense

Who is Covered:

[Individual]

[Individual & Family Members]

Limit Per Loss:

[\$[Insert Limit]

Coverage Period Options:

[[Insert Number] [Month] [Year] [s]]

[Monthly]

Premium Rate For Selected Coverage:

[\$[Insert Rate] per Eligible Person per [Insert Number (if applicable)] [month] [years] [s]]

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APPLICATION

I _____ apply for the following coverage(s):

- [Emergency Medical Expense Benefit]
- [Ambulance and Paramedic Expense Benefit]
- [Health Insurance Deductible Reimbursement Benefit]
- [Child's Accident Expense Benefit]

I have read, understand and agree to all Terms and Conditions for the coverage(s) selected. I authorize Virginia Surety Company, Inc. to collect premium payment. I understand that once the application is processed, coverage becomes effective on the effective date stated on the Schedule of Coverage, provided the premium is paid. Please see the fraud warning notice below.

Signature/Date

General Fraud Notice: 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 may be a crime and may subject such person to criminal and civil penalties.

[Residents of [Arkansas], [New Mexico], [and] [Ohio]: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[Residents of Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance.]

[Residents of the [District of Columbia] [and] [Tennessee]: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.]

[Residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[Residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.]

[Residents of Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance contract is subject to criminal or civil penalties.]

[Residents of New York: 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[Residents of Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[Residents of Pennsylvania: 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 subject such person to criminal and civil penalties.]

[Residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

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AMENDATORY ENDORSEMENT

THIS ENDORSEMENT CHANGES THE POLICY, PLEASE READ IT CAREFULLY

Policy Number: [Insert Policy Number]

Effective Date of this Endorsement: [Insert Endorsement Effective Date]

It is agreed that the following revisions are made to the above captioned policy:

DISPUTE RESOLUTION – ARBITRATION is deleted in its entirety:

LEGAL ACTION is replaced with the following:

Legal Actions: No action at law or in equity shall be brought to recover under the **Policy** prior to the expiration of five (5) years after proof of loss has been furnished in accordance with the requirements of this coverage.

SUBROGATION is replaced with the following:

Subrogation: When You have been fully compensated for Your **Loss** and there has been payment by Us under this **Policy** for that **Loss**, then We are entitled to recover those amounts that have exceeded the amount of Your **Loss**. In order to accomplish this, You agree that You will transfer Your rights to recovery against any other party or person for the amount of the excess over the amount of Your **Loss**. With respect to the excess amount, You agree to everything necessary for Us to secure these rights and to do nothing that would jeopardize these rights to recovery from any other party or person.

All other provisions remain unchanged.

VIRGINIA SURETY COMPANY, INC.

[John Smith]
President

SERFF Tracking Number: ICCI-126233452 State: Arkansas
Filing Company: Virginia Surety Company, Inc. State Tracking Number: 42931
Company Tracking Number: EM-COI (12.08) A&H
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: Group Emergency Medical filing EM-COI (12.08) A&H
Project Name/Number: Group Emergency Medical filing EM-COI (12.08) A&H/Group Emergency Medical filing EM-COI (12.08) A&H

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 07/23/2009
Comments:
Attachment:
AR readability certification Group EM - 6-24-09.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 07/23/2009
Comments:
See Form Schedule tab

Satisfied -Name: Statement of Variability **Review Status:** Approved-Closed 07/23/2009
Comments:
Attachment:
Statement of Variability Group - Emergency Medical.pdf

FLESCH READING EASE TEST CERTIFICATION

This is to certify that the forms listed below are in compliance with readability requirements of the Flesch Reading Ease Test, and the requirements of your state.

The Flesch Test was applied to the forms in their entirety, except that company name and address, form numbers, titles, captions, subcaptions, schedules, tables, defined words, and text required by law or regulation were excluded.

The Flesch Reading Ease scores are as follows:

<u>FORM NUMBERS</u>	<u>FLESCH SCORE</u>
EM-MEMF-COI (12.08)	42.493
EM-MEMI-COI (12.08)	42.493
EM-PAKF-COI (12.08)	42.493
EM-PAKI-COI (12.08)	42.493
EM-SOC (12.08)	combined with certificate

VIRGINIA SURETY COMPANY, INC.

JUNE 23, 2009

Date

Joseph D. Fagan

Signature of Officer

Joseph D. Fagan, Vice President and Senior Counsel
Name & Title of signer

Virginia Surety Company, Inc.
Statement of Variability

Emergency Medical

AT NO TIME WILL ANY VARIABLES BE USED TO CHANGE ANY PROVISION IN A MANNER THAT IS NOT IN COMPLIANCE WITH APPLICABLE STATE OR FEDERAL LAW.

This is a listing of items that relate to the use of variable brackets within the forms.

Administrators:

Including but not limited to:

- TWG Innovative Solutions, 13922 Denver West Parkway, Golden, CO 80401;
- cynoSure Financial, Inc., P.O. Box 7690, St. Clair Shores, MI 48080;
- Affinion Group, 7814 Carousel Lane, Richmond, VA. 23294.

Auto/Home Related Accident:

For two of the benefits (Emergency Medical Expense and ambulance and paramedic expense) coverage is provided for either an auto or home related accident or both. To help identify the language used for either option the auto related accident language is highlighted in yellow or the home related accident language is highlighted in green.

Coverage Period:

- Variation #1 – **Coverage Period** means the period starting on the **Membership Effective Date** and will continue for [Insert Program Term]. [Insert Program Term] will be populated with the term that is being offered.
- Variation #2 – **Coverage Period** means the period starting on the **Membership Effective Date** and will continue monthly.

Definitions:

Unnecessary definitions will be deleted based on applicability to the particular plan design selected by a Policyholder/Insured.

Program:

- [Insert Program] will be populated with the name that the program is marketed under.

Limits:

- [Insert Dollar Limit] will be populated with the coverage limit chosen from the rate and rule manual.

Other variables:

- Other items that customarily vary according to the policyholder's specific plan of insurance.
- The Schedule of Coverage/Declaration Page shall be considered as variable to illustrate the specific terms of coverage offered by the company and chosen by the policyholder.
- We also reserve the right to amend the forms to fix any minor typographical errors we may have neglected to find prior to submitting for approval.