

SERFF Tracking Number: WESA-126907653 State: Arkansas  
Filing Company: United States Fire Insurance Company State Tracking Number: 47357  
Company Tracking Number: AH27700  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: United States Fire Occupational Accident  
Project Name/Number: United States Fire Occupational Accident/AH27700

## Filing at a Glance

Company: United States Fire Insurance Company

Product Name: United States Fire Occupational SERFF Tr Num: WESA-126907653 State: Arkansas

Accident

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-  
Closed

State Tr Num: 47357

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: AH27700

State Status: Approved-Closed

Filing Type: Form

Authors: Darcy Lebau, Carolyn  
Smart

Reviewer(s): Rosalind Minor

Disposition Date: 11/29/2010

Date Submitted: 11/19/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: United States Fire Occupational Accident

Project Number: AH27700

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/29/2010

Deemer Date:

Submitted By: Darcy Lebau

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Trust

Explanation for Other Group Market Type:

State Status Changed: 11/29/2010

Created By: Darcy Lebau

Corresponding Filing Tracking Number:

AH27700

Filing Description:

November 19, 2010 via SERFF

The Honorable Julie Benafield Bowman

Commissioner of Insurance

Arkansas Insurance Department

1200 West Third Street

SERFF Tracking Number: WESA-126907653 State: Arkansas  
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Product Name: United States Fire Occupational Accident  
Project Name/Number: United States Fire Occupational Accident/AH27700  
Little Rock, AR 72201  
Attention: Life & Health Division

Re: United States Fire Insurance Company  
FEIN#: 13-5459190  
NAIC#: 0158-21113

Occupational Accident Policy Form Number AH27700  
Certificate of Insurance Form Number AHC27700  
Participation Agreement Form Number AH27400-PA  
Application Form Number DA-27700  
Owner/Operator Request for Insurance Form Number AH27440-ORQ  
Dependent Coverage Rider Form Number AHE-27700-DR-AR  
Coma Benefit Rider Form Number AHE- 27700-CCR  
Emergency Evacuation Benefit Rider Form Number AHE-27700- EER  
Felony Assault Benefit Rider Form Number AHE-27700-FBR  
Hemorrhoid Benefit Rider Form Number AHE-27700-HBR  
Hernia Benefit Rider Form Number AHE-27700-Hernia Rider  
Hijacking Benefit Rider Form Number AHE-27700-Hijacking Benefit Rider  
Home Alteration and Vehicle Form Number AHE-27700-HAVM  
Modification Benefit Rider  
In-Hospital Indemnity Benefit Rider Form Number AHE-27700-IHI  
Natural Disaster Benefit Rider Form Number AHE-27700-NDB  
Passenger Coverage Rider Form Number AHE-27700-PE  
Rehabilitation Benefit Rider Form Number AHE-27700-RB  
Seat Belt and Airbag Benefit Rider Form Number AHE-27700-SBAB  
Trauma Counseling Benefit Rider Form Number AHE-27700-TCB  
Arkansas Amendatory Endorsement Form Number AHE-27700-AR

Honorable Commissioner Bowman:

I respectfully submit the form filing referenced above on behalf of United States Fire Insurance Company ("United States Fire") for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of United States Fire. Please see the enclosed authorization letter.

This is a trust filing utilizing the Group and Blanket Accident & Health Insurance Trust (the "Trust") as originally agreed to by TIG Insurance Company (the Administrator) and Marine Bank, Springfield, Illinois (the Trustee) and dated May 30,

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2001. A copy of the Trust Agreement is provided for your reference. By Amendment dated January 1, 2006, the Trust Agreement was amended to include United States Fire as "Administrator". Insurance contracts will be issued to the Trustee for the benefit of participants that have been approved for such insurance. This Trust has been utilized in several previous United States Fire filing in Illinois and was approved.

Occupational Accident Policy, Form #AH27700, covers a broad class of persons for specific losses related to specific activities. The subject forms are new and are not intended to replace any other forms currently in use.

Occupational Accident Policy, Form #AH27700, provides accident benefits on generally a voluntary blanket basis to participants (e.g., motor carriers or other participating organizations) to cover non-employee independent contractors. However, coverage or supplemental coverage may also be provided on a non-contributory basis. United States Fire files these forms as variable; offering accidental death and dismemberment benefits, disability income benefits, and accident medical/dental expense benefits either separately or in combination. The forms as filed are more inclusive than the forms as they will be issued on a specific case or program. Variable data is bracketed and italicized and may vary on a case or program basis. Please see the enclosed Statements of Variability for United States Fire's explanation of how these forms may vary to accommodate different product offerings

The Certificate of Insurance, Form #AHC27700, will be issued to describe the plan of benefits offered when required by law or as requested by the Participating Organization.

By the Application, Form #DA27700, the Group and Blanket Accident & Health Insurance Trust will request that United States Fire provide insurance under the aforementioned Policy.

By the Participation Agreement, Form #AH277400-PA, the participating organization will apply to United States Fire to participate in the Group and Blanket Accident & Health Insurance Trust. Such participation entitles the organization to coverage for its Independent Contractors under the said Trust.

The Request for Insurance, Form # AH27440-ORQ, identifies the person(s) covered and detail the benefits applicable to such persons covered and will be signed by the Owner/Operator.

The Riders listed may be selected at the option of the Participating Organization.

The Occupational Accident Insurance product will be marketed by licensed agents, brokers, and third party administrators to eligible participating organizations.

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In accordance with Arkansas' filing requirements, enclosed please find:

- Letter of Authorization
- Readability Certification, excluding the state mandated language endorsement, form # AH27000-AR
- Forms
- Statements of Variability
- Consumer Information Notice
- Trust Agreement
- Life & Health Guaranty Association Act Notice to Policyholders

I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 221 or at Darcy@Westmontlaw.com if you have any questions or require additional information.

Respectfully,

Darcy Lebau

Darcy Lebau

## Company and Contact

### Filing Contact Information

Darcy LeBau, darcy@westmontlaw.com  
25 Chestnut Street, Suite 105 856-216-0220 [Phone]  
Haddonfield, NJ 08033

### Filing Company Information

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

United States Fire Insurance Company	CoCode: 21113	State of Domicile: Delaware
305 Madison Avenue	Group Code: 158	Company Type:
Morristown, NJ 07960-6117	Group Name:	State ID Number:
(973) 490-6600 ext. [Phone]	FEIN Number: 13-5459190	

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Project Name/Number: United States Fire Occupational Accident/AH27700

## Filing Fees

Fee Required? Yes  
Fee Amount: \$1,050.00  
Retaliatory? Yes  
Fee Explanation: Delaware, United States Fire Insurance Company's state of domicile, charges \$50 per form. 21 forms @ \$50 per form = \$1050.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United States Fire Insurance Company	\$1,050.00	11/19/2010	42129873

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/29/2010	11/29/2010

### 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	11/24/2010	11/24/2010	Darcy Lebau	11/29/2010	11/29/2010

*SERFF Tracking Number:* WESA-126907653      *State:* Arkansas  
*Filing Company:* United States Fire Insurance Company      *State Tracking Number:* 47357  
*Company Tracking Number:* AH27700  
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*Product Name:* United States Fire Occupational Accident  
*Project Name/Number:* United States Fire Occupational Accident/AH27700

## **Disposition**

Disposition Date: 11/29/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WESA-126907653 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statements of Variability	Approved-Closed	Yes
Supporting Document	Letter of Authorization	Approved-Closed	Yes
Supporting Document	Trust Agreement	Approved-Closed	Yes
Supporting Document	Consumer Information Notice	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form (revised)	CERTIFICATE OF INSURANCE	Approved-Closed	Yes
Form	CERTIFICATE OF INSURANCE	Replaced	Yes
Form	COMA BENEFIT RIDER	Approved-Closed	Yes
Form (revised)	DEPENDENT COVERAGE RIDER	Approved-Closed	Yes
Form	DEPENDENT COVERAGE RIDER	Replaced	Yes
Form	EMERGENCY EVACUATION BENEFIT RIDER	Approved-Closed	Yes
Form	FELONIOUS ASSAULT BENEFIT RIDER	Approved-Closed	Yes
Form	HEMORRHOID BENEFIT RIDER	Approved-Closed	Yes
Form	HERNIA BENEFIT RIDER	Approved-Closed	Yes
Form	HIJACKING BENEFIT RIDER	Approved-Closed	Yes
Form	HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT RIDER	Approved-Closed	Yes
Form	IN-HOSPITAL INDEMNITY BENEFIT RIDER	Approved-Closed	Yes
Form	APPLICATION	Approved-Closed	Yes
Form	NATURAL DISASTER BENEFIT RIDER	Approved-Closed	Yes
Form	PARTICIPATION AGREEMENT	Approved-Closed	Yes
Form	OCCUPATIONAL ACCIDENT POLICY	Approved-Closed	Yes
Form	REHABILITATION BENEFIT RIDER	Approved-Closed	Yes
Form	OWNER/OPERATOR REQUEST FOR INSURANCE	Approved-Closed	Yes
Form	SEAT BELT AND AIR BAG BENEFIT RIDER	Approved-Closed	Yes
Form	TRAUMA COUNSELING BENEFIT RIDER	Approved-Closed	Yes
Form	PASSENGER COVERAGE RIDER	Approved-Closed	Yes
Form	ARKANSAS LIFE & HEALTH INSURANCE GUARANTY	Approved-Closed	Yes

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*Product Name:* United States Fire Occupational Accident  
*Project Name/Number:* United States Fire Occupational Accident/AH27700

	ASSOCIATION NOTICE		
<b>Form (revised)</b>	ARKANSAS AMENDATORY ENDORSEMENT	Approved-Closed	Yes
<b>Form</b>	ARKANSAS AMENDATORY ENDORSEMENT	Replaced	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 11/24/2010

Submitted Date 11/24/2010

Respond By Date

Dear Darcy LeBau,

This will acknowledge receipt of the captioned filing.

Objection 1

- DEPENDENT COVERAGE RIDER, AHE-27700-DR-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 11/29/2010  
 Submitted Date 11/29/2010

Dear Rosalind Minor,

### Comments:

Good morning, Ms. Minor.

Please accept this Response Letter as United State Fire Insurance Company's response to your objection letter dated 11/24/2010.

### Response 1

Comments: Please see revised Dependent Coverage Rider. Further, please see revised Certificate and Amendatory Endorsement. The Notice to Arkansas residents was moved fromt the Amendatory Endorsement to the face page of the Certificate.

### Related Objection 1

Applies To:

- DEPENDENT COVERAGE RIDER, AHE-27700-DR-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
CERTIFICATE OF	AHC2770		Certificate	Initial		50.200	Certificate

SERFF Tracking Number: WESA-126907653 State: Arkansas  
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 Project Name/Number: United States Fire Occupational Accident/AH27700

INSURANCE 0 11-3-10.docCL  
 EAN1110  
 2010.docr  
 ev11 29  
 2010CLE  
 AN.pdf

**Previous Version**

CERTIFICATE OF INSURANCE AHC2770 0 Certificate Initial 50.200 Certificate  
 11-3-10.docCL  
 EAN1110  
 2010.pdf  
 DEPENDENT AHE- Policy/Contract/Fraternal Initial 50.200 Dependen  
 COVERAGE RIDER 27700- Certificate: Amendment, t  
 DR-AR Insert Page, Endorsement Coverage  
 or Rider or Rider 11-3-10.docCL  
 EANAR.d  
 ocrev1124  
 2010.pdf

**Previous Version**

DEPENDENT AHE- Policy/Contract/Fraternal Initial 50.200 Dependen  
 COVERAGE RIDER 27700- Certificate: Amendment, t  
 DR-AR Insert Page, Endorsement Coverage  
 or Rider or Rider 11-3-10.docCL  
 EANAR.p  
 df  
 ARKANSAS AHE- Policy/Contract/Fraternal Initial 50.200 AR Rider  
 AMENDATORY 27700-AR Certificate: Amendment, OA.docv4.  
 ENDORSEMENT Insert Page, Endorsement docCLEA  
 or Rider or Rider N11 29  
 2010.pdf

SERFF Tracking Number: WESA-126907653 State: Arkansas  
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Product Name: United States Fire Occupational Accident  
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**Previous Version**

ARKANSAS	AHE-	Policy/Contract/Fraternal Initial	50.200	AR Rider
AMENDATORY	27700-AR	Certificate: Amendment,		OA.docv4.
ENDORSEMENT		Insert Page, Endorsement		pdf
		or Rider		

No Rate/Rule Schedule items changed.

Thank you for your time and attention to this filing.

Respectfully,

Darcy Lebau

Sincerely,  
Carolyn Smart, Darcy Lebau

SERFF Tracking Number: WESA-126907653 State: Arkansas  
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## Form Schedule

### Lead Form Number: AH27700

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/29/2010	AHC27700	Certificate	CERTIFICATE OF INSURANCE	Initial		50.200	Certificate11-3-10.docCLEAN 11102010.doc rev11 29 2010CLEAN. pdf
Approved-Closed 11/29/2010	AHE-27700-CCR	Policy/Contract	COMA BENEFIT RIDER	Initial		50.200	Coma Rider.pdf
Approved-Closed 11/29/2010	AHE-27700-DR-AR	Policy/Contract	DEPENDENT COVERAGE RIDER	Initial		50.200	Dependent Coverage Rider 11-3-10.docCLEAN AR.docrev11242010.pdf
Approved-Closed 11/29/2010	AHE-27700-EER	Policy/Contract	EMERGENCY EVACUATION BENEFIT RIDER	Initial		50.200	Emerg Evac Rider.pdf

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Page	Endorsement or Rider	Policy/Contract	Benefit	Initial	Amount	Document
Approved- Closed 11/29/2010	AHE- 27700-FBR	Policy/Cont rict/Fratern al	FELONIOUS ASSAULT BENEFIT RIDER	Initial	50.200	Felonious Assault Benefit.pdf
Certificate: Amendment, Insert Page, Endorsement or Rider						
Approved- Closed 11/29/2010	AHE- 27700-HBR	Policy/Cont rict/Fratern al	HEMORRHOID BENEFIT RIDER	Initial	50.200	Hemorrhoid Rider.pdf
Certificate: Amendment, Insert Page, Endorsement or Rider						
Approved- Closed 11/29/2010	AHE- 27700- Hernia Rider	Policy/Cont rict/Fratern al	HERNIA BENEFIT RIDER	Initial	50.200	Hernia Rider.pdf
Certificate: Amendment, Insert Page, Endorsement or Rider						
Approved- Closed 11/29/2010	AHE- 27700- Hijacking Benefit Rider	Policy/Cont rict/Fratern al	HIJACKING BENEFIT RIDER	Initial	50.200	Hijacking Benefit Rider.pdf
Certificate: Amendment, Insert Page, Endorsement						

<i>SERFF Tracking Number:</i>	WESA-126907653	<i>State:</i>	Arkansas
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<i>Project Name/Number:</i>	United States Fire Occupational Accident/AH27700		
Approved- AHE- Closed 27700- 11/29/2010 HAVM	Policy/Cont HOME ALTERATION Initial ract/Fratern AND VEHICLE al MODIFICATION Certificate: BENEFIT RIDER Amendmen t, Insert Page, Endorseme nt or Rider	50.200	Home alteration Rider.pdf
Approved- AHE-27700 Closed 11/29/2010	Policy/Cont IN-HOSPITAL Initial ract/Fratern INDEMNITY al BENEFIT RIDER Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.200	In-hosp Indemnity Rider.pdf
Approved- DA-27700 Closed 11/29/2010	Application/ APPLICATION Initial Enrollment Form	50.200	Master APP.pdf
Approved- AHE- Closed 27700- 11/29/2010 NDB	Policy/Cont NATURAL Initial ract/Fratern DISASTER BENEFIT al RIDER Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	50.200	Natural Disaster Rider.pdf
Approved- AH27400- Closed PA 11/29/2010	Application/ PARTICIPATION Initial Enrollment AGREEMENT Form	50.200	Participating Agreement.pdf
Approved- AH27700 Closed 11/29/2010	Policy/Cont OCCUPATIONAL Initial ract/Fratern ACCIDENT POLICY al Certificate	0.000	Policy Pages 11-3-10.pdf

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Project Name/Number:	United States Fire Occupational Accident/AH27700			
Approved- AHE- Closed 27700-RB 11/29/2010	Policy/Cont REHABILITATION ract/Fratern BENEFIT RIDER al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.200	Rehab Rider.pdf
Approved- AH27440- Closed ORQ 11/29/2010	Application/OWNER/OPERATO Enrollment R REQUEST FOR Form INSURANCE	Initial	50.200	Request for Insurance docCLEAN11 082010.pdf
Approved- AHE- Closed 27700- 11/29/2010 SBAB	Policy/Cont SEAT BELT AND ract/Fratern AIR BAG BENEFIT al RIDER Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.200	Seatbelt Airbag Rider.pdf
Approved- AHE- Closed 27700- 11/29/2010 TCB	Policy/Cont TRAUMA ract/Fratern COUNSELING al BENEFIT RIDER Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.200	Trauma Counseling Rider.pdf
Approved- AHE- Closed 27700-PE 11/29/2010	Policy/Cont PASSENGER ract/Fratern COVERAGE RIDER al Certificate: Amendmen t, Insert Page,	Initial	50.200	Passenger Coverage Rider.pdf

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Endorsement or Rider

Approved- AR=Guaranty	Other	ARKANSAS LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION NOTICE	Initial		Arkansas Guaranty Association Notice.pdf
Closed 11/29/2010					
Approved- AHE-27700-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	ARKANSAS AMENDATORY ENDORSEMENT	Initial	50.200	AR Rider OA.docv4.doc CLEAN11 29 2010.pdf
Closed 11/29/2010					

# UNITED STATES FIRE INSURANCE COMPANY

(Herein Called "We, "Our", or "Us")

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## CERTIFICATE OF INSURANCE

This Certificate of Insurance is issued under the terms of the Policy issued to the Policyholder. We insure each person in one of the Eligible Classes provided the application is received and the required premium is paid when due.

We will pay the benefits described in this Certificate for certain losses resulting directly and independently of all other causes from an Injury sustained in an Occupational Accident that occurs while the Policy is in force and Your coverage is in effect. Your insurance is subject to all the provisions, conditions, exclusions and limitations of the Policy.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Signature



Douglas M. Libby  
Chairman and CEO

Signature



James Kraus  
Secretary

### IMPORTANT NOTICE

**THIS IS A CERTIFICATE FOR OCCUPATIONAL ACCIDENT BENEFITS ONLY. BENEFITS ARE NOT PAID FOR SICKNESS OR ANY OTHER TYPE OF INJURY. THIS POLICY IS NOT WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

**[Arizona Residents: NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL THE BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.]**

**[Arkansas Residents: THIS CERTIFICATE IS NOT A WORKERS' COMPENSATION CONTRACT AND IS NOT A SUBSTITUTE FOR WORKERS' COMPENSATION COVERAGE AND DOES NOT COVER ANY PERSON WHO IS REQUIRED TO BE COVERED BY A WORKERS' COMPENSATION CONTRACT.]**

**[Florida Residents: The Benefits of the policy providing *Your* coverage are governed primarily by the law of a state other than Florida.]**

**[Texas Residents:**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM. THIS INSURANCE DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

**[West Virginia Residents: **Right to Return** – *You* have the right to return this Certificate to us or our agent for cancellation within 10 days of its delivery to you. The full amount of *Your* premium will be refunded to *You*, if, after examination of this certificate *You* are not satisfied for any reason.]**

**PLEASE READ THIS CERTIFICATE CAREFULLY.**

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## SCHEDULE OF BENEFITS

This Schedule of Benefits is a very brief summary of Your benefits. A more complete description of the benefits is in this Certificate.

**Policyholder:** [The Group and Blanket Accident & Health Insurance Trust]

**Policy Number:** [AH27700-006]

**Participant:** [XYZ Motor Carrier]

**Participant's Effective Date:** [date]

**Participant's Anniversary Date:** [date] and each [date] thereafter.

**Insured:** [John Doe.]

**Social Security Number:** [000-00-0000]

**Insured's Effective Date:** [date]

### Eligible Classes:

[Class 1	Owner/Operator
Class 2	Scheduled Co-Driver
Class 3	Scheduled Contract Driver of Owner/Operator
Class 4	Scheduled Laborer]

All references to "You" or "Your" in this Certificate means the Insured who is included in an Eligible Class. Coverage is provided to a person in an Eligible Class under this Certificate **ONLY** under the following circumstances:

**As an Owner/Operator:** You will be covered only while:

- (a) You are Under Contract to the Participant and performing Your contractual obligations under that contract; and
- (b) You are not on a Personal Deviation. "Personal Deviation" means:
  1. an activity that is not reasonably related to the Participant's business/Participant's activities; and
  2. not incidental to the performing Your contractual obligations.

**[If You are in an Eligible Class other than Owner/Operator:** You will be covered only:

- (a) If an Insured Owner/Operator has submitted a Request to cover You;
- (b) The Insured Owner/Operator's Request has been accepted by Us;
- (c) You are Under Contract to the Participant or Owner/Operator and performing Your contractual obligations under that contract; and
- (d) You are not on a Personal Deviation. "Personal Deviation" means:
  1. an activity that is not reasonably related to the Participant's or Owner/Operator's business activities; and
  2. not incidental to the performing Your contractual obligations.]

**Required Waiting Period:** No waiting period for Accident Medical/Dental Expense. See other Benefits for any Waiting Period specific to the Benefit.

**Who Pays For the Coverage:** [You must pay the cost of Your coverage under this Plan.]

**Premium Due Date:** [The 1<sup>st</sup> of each month]

**Age Limit:** You will not be covered after You reach age [65]

**SCHEDULE OF BENEFITS  
(Continued)**

**COVERAGE PROVIDED**

**Occupational Accident:** Covered  
**[Occupational Disease:** Covered]  
**[Cumulative Trauma:** Covered]  
**[Hernia:** Covered]  
**[Non-Occupational Accident:** See Endorsement Attached]  
**[Dependent Coverage:** See Endorsement Attached]

**[INSTALLMENT PAYMENT OPTION ELECTED FOR DEATH BENEFITS: \_\_\_ YES \_\_\_ NO]**

**AMOUNTS OF INSURANCE**

<b>Class</b>	<b>Accidental Death and Dismemberment Principal Sum</b>	<b>Temporary Total Disability Weekly Benefit</b>	<b>Permanent Total Disability Monthly Benefit</b>	<b>Accident Medical/Dental Expense Benefit Maximum Benefit</b>
[1	\$50,000	(a)	(b)	\$100,000 per accident
2	\$50,000	(a)	(b)	\$100,000 per accident
3	\$25,000	(a)	(b)	\$100,000 per accident
4	\$10,000	(a)	(b)	\$100,000 per accident]

[(a) 70% of Average Weekly Earnings, subject to a maximum amount of \$500 per week [minus Other Income Benefits].  
(b) 4.3 times Average Weekly Earnings multiplied by 0.70, subject to a maximum amount of \$1,505 per month minus Other Income Benefits.]

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

**Time Limit For Loss:** [180] [365] days from date of the Occupational Accident]

**TOTAL DISABILITY BENEFITS**

**Daily Benefit**

Temporary Total Disability – [1/7th of the Weekly Benefit]

Permanent Total Disability- [1/30th of the Monthly Benefit]

**Benefit Waiting Period**

Temporary Total Disability- [7 days of continuous Total Disability ]

Permanent Total Disability- [180 days of continuous Total Disability]

**[Maximum Payment Period**

Temporary Total Disability- 26 weeks  
Permanent Total Disability- 60 months]

**[Reduction in Disability Income Benefits**

The amount of Your Temporary Total or Permanent Total Disability Income Benefits will be reduced by the amount of any [Other Income Benefits / Social Security benefits] payable to You on account of such disability. This amount will include any benefits payable for Your dependents. Cost-of-living increases in Social Security payments effective after Your correct Social Security benefit has been determined will not be used to reduce Your Disability Income Benefit.]

**SCHEDULE OF BENEFITS  
(Continued)**

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFITS**

**Time Limit for Loss**

Treatment must begin within [30][60][90] days from the date of Injury in a covered Occupational Accident.

**Maximum Payment Period**

Benefits are payable for [[6] [12] months] [[52][104] weeks] from the date of the covered Injury. The Injury must occur after the Effective Date and prior to the Expiration Date and care must be Appropriate Care.

**[Deductible**

[\$50] per Covered Person per Occupational Accident]

**Coinsurance Rate**

[100%] of Reasonable Charges

**[COMBINED SINGLE BENEFIT LIMIT**

Not more than [\$1,000,000] will be paid under **all benefits** (Accidental Death and Dismemberment, Disability Income and Accident Medical/Dental Expense Benefits combined) for any one person due to any one Occupational Accident.]

**[ADDITIONAL BENEFITS** – See Endorsement(s) Attached]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

**[This benefit is subject to the Combined Single Benefit Limit shown in the Schedule of Benefits.]**

If You have an Occupational Accident while covered under the Policy, We will pay the Percent of the Principal Sum shown below for the Covered Loss named below. To be covered the loss must meet all of the following requirements:

- (1) The loss must be the direct result of an Injury sustained in an Occupational Accident.
- (2) The Occupational Accident must occur while You are covered under this Policy.
- (3) The loss must occur within the Time Limit shown in the Schedule of Benefits.

The Principal Sum is shown in the Schedule of Benefits. Only one benefit, the highest, will be paid if You suffer more than one Covered Loss in an Occupational Accident.

<b>Covered Loss</b>	<b>Percent of Principal Sum</b>
[Life.....	100%
Both Hands, Both Feet, or Sight of Both Eyes .....	100%
Any combination of Foot, Hand or Sight of One Eye.....	100%
Speech and Hearing in Both Ears .....	100%
Use of Both Arms and Both Legs.....	100%
Use if One Arm and One Leg on One Side of the Body.....	75%
Use if Both Arms or Both Legs .....	75%
One Hand, One Foot or Sight of One Eye.....	50%
Speech .....	50%
Hearing in One Ear.....	25%
Thumb and Index Finger of Same Hand .....	25%]

[Loss of Hand means removal at or above the wrist joint.] [Loss of Foot means removal at or above the ankle joint.] [Loss of Sight means total loss of sight that cannot be recovered.] [Loss of Speech means total loss of speech that cannot be recovered.] [Loss of Hearing means total loss of hearing that cannot be recovered.] [Loss of Use means complete paralysis of the entire limb that cannot be recovered. A Physician must determine the loss of use to be complete and not reversible at the time the claim is submitted.] [Loss of Thumb and Index Finger means removal at or above the last joint of both.]

Benefits for loss of life are paid to Your beneficiary. Benefits for other losses are paid to You.

**Beneficiary**

You have the right to change Your beneficiary and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary. A beneficiary may be changed by filling out a Change of Beneficiary form. You can get this form from the Participant. The form must be received and recorded by the Participant before the change of beneficiary becomes effective.

**Not Covered**

No payment will be made for any loss caused or contributed to by the following:

- (1) Disease, bodily or mental infirmity, functional nervous or emotional disorders, with or without a demonstrable organic cause, or any medical or surgical treatment, or diagnostic procedures for any of these, or for any condition or treatment that is not the direct result of an injury sustained in a covered Occupational Accident,
- (2) Ptomaine or bacterial infection, other than pyogenic or bacterial infection occurring as a consequence of an accidental cut or wound sustained in an Occupational Accident.

Other exclusions that apply to this benefit are in **General Exclusions.]**

## **[DISABILITY INCOME BENEFIT**

**[This benefit is subject to the Combined Single Benefit Limit shown in the Schedule of Benefits.]**

If You become Totally Disabled due to an injury sustained in an Occupational Accident that happens while covered under the Policy, You will be paid the benefits described below.

You must satisfy the Benefit Waiting Period and be under the Appropriate Care of a Physician. You must provide Us with satisfactory proof of Your Total Disability, at Your expense, before benefits will be paid. We will require continued proof of Your Total Disability be provided from time to time at Your expense for benefits to continue.

### **Temporary Total Disability**

Payments will start as shown in the Schedule of Benefits. Payments will stop on the earliest of the following:

- (1) The date Your Total Disability stops.
- (2) The date You return to work unless Your return to work qualifies You for Partial Disability Benefits as described in the Policy.
- (3) When the Maximum Payment Period for Temporary Total Disability shown in the Schedule of Benefits is reached.
- (4) The date You reach the Age Limit shown in the Schedule of Benefits.

### **[Partial Disability Benefit**

If You return to Your regular occupation on a part-time basis, or any other occupation on a full-time or part-time basis, Your Temporary Total Disability Benefits will be reduced. For any week, if the sum of Your Temporary Total Disability Benefit, current earnings and any additional Other Income Benefits exceed 100% of Your Average Weekly Earnings, Your Temporary Total Disability Benefit will be reduced by the excess amount.]

### **Permanent Total Disability**

Payments will start on the latest of:

- (1) The date You satisfy the Benefit Waiting Period shown in the Schedule of Benefits for this benefit.
- (2) The first day of the week after the Maximum Payment Period under Temporary Total Disability is reached.
- (3) The date You are granted a Social Security Disability Award for the Total Disability.

Payments will stop on the earliest of the following:

- (1) The date Your Total Disability stops.
- (2) The date You return to work.
- (3) When the Maximum Payment Period for Permanent Total Disability shown in the Schedule of Benefits is reached.
- (4) The date You reach the Age Limit shown in the Schedule.
- (5) The date Your Social Security Disability Award stops.

### **MAXIMUM PAYMENT PERIODS**

The Maximum Payment Periods shown in the Schedule of Benefits are for each period of disability.

**DISABILITY INCOME BENEFIT**  
**(Continued)**

**SUCCESSIVE PERIODS OF DISABILITY**

Once You are Totally Disabled under the Policy, separate periods of Total Disability resulting from the same or related causes are a continuous period of Total Disability unless You return to work for at least 6 months between periods of Total Disability. Only one Benefit Waiting Period and Maximum Payment Period apply to any one period of continuous Total Disability.

A period of Total Disability is not continuous if separate periods of Total Disability result from unrelated causes, or Your later Total Disability occurs after Your coverage under the Policy ends. This provision will not apply if You are eligible for coverage under a plan that replaces the Policy.

**Not Covered**

No payment will be made for any Total Disability for which benefits are payable under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted.

Other exclusions that apply to this benefit are in **General Exclusions.**]

**[ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT**

**[This benefit is subject to the Combined Single Benefit Limit shown in the Schedule of Benefits.]**

The Accident Medical Expense Benefit provides payment for the Covered Expenses shown below. These expenses must be charged to You while covered. These expenses must be ordered by a Physician as Medically Necessary for Injuries that result directly and from no other causes from an Occupational Accident. [These benefits are subject to the Deductible, Coinsurance Rate, Maximum Payment Periods, and Maximum Benefits shown in the Schedule of Benefits.]

**Maximum Benefit**

The Maximum Benefit for any one Occupational Accident is shown in the Schedule of Benefits.

**Covered Expenses**

Covered Expenses are the actual cost to You of the Reasonable Charges for the services and supplies listed below. The service or supply must be:

- (1) Ordered by a Physician for the diagnosis or treatment of an Occupational Accident.
- (2) Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We, at our discretion, may consider the cost of that alternative to be Covered Expenses. In this case, Covered Expenses are limited to the Reasonable Charges for that diagnostic or treatment alternative.

We pay Covered Expenses:

- (1) after the Covered Person satisfies any deductible; and
- (2) [only when they are in excess of amounts paid by any other Health Care Plan, except for the first \$100 of claims.]  
[We pay benefits without regard to any coordination of benefits provisions in any other Health Care Plan.]

Covered Expenses include:

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT  
(Continued)**

**[Ambulance Services**

Transportation for a Medical Emergency

- (1) By professional ambulance, other than air ambulance, to and from a Hospital.
- (2) By regularly scheduled airline, railroad or air ambulance to the nearest Hospital qualified to give the required treatment.

These services must be given within the United States or Canada.]

**[Ambulatory Surgical Center Charges**

Medically Necessary charges for a Center's services given on the day of a surgical procedure. The services have to be given in connection with the procedure.]

**[Anesthetics**

Anesthetics and charges for giving them.]

**[Dental Services**

Coverage for dental services is limited to the following as the result of an Occupational Accident that happens while covered:

- (1) Appliances and splints placed on or attached to natural teeth.
- (2) Full or partial dentures.
- (3) Fixed bridgework if needed because of Occupational Accidental injury to natural teeth.
- (4) Prompt repair to natural teeth if needed because of Occupational Accidental injury to those teeth.]

**[Health Care Provider's Services**

Services of a licensed or certified Health Care Provider acting within the scope of that license or certification. Covered Expenses given by a Health Care Provider are payable on the same basis as Covered Expenses given by a Physician.]

**[Hospital Charges**

The daily room rate when a You are confined in a Hospital, general nursing care provided and charged for by the Hospital, and ancillary Hospital expenses for services and supplies, including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) while You are confined in a Hospital.]

**[Laboratory Tests and X-rays**

X-rays or tests for diagnosis or treatment.]

**[Medical Supplies**

- (1) Prescribed drugs and medicines.
- (2) Surgical supplies (such as bandages and dressings).
- (3) An appliance that replaces a lost body organ or part or helps an impaired one to work. An appliance will be replaced only if damaged as the result of an Occupational Accident that happens while covered.
- (4) Oxygen and charges for giving it. This includes rental of required equipment.
- (5) Rental of a wheel-chair or hospital-type bed.
- (6) Rental of a device to help breathing when paralyzed.]

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT  
(Continued)**

**[Nursing Services**

Services of a trained nurse. The services of a private duty nurse, while You are confined in a hospital, may not always be deemed Medically Necessary. In any case when such services are not deemed Medically Necessary, charges made by a private duty nurse will not be considered Covered Expenses. No benefits will be paid for such private duty nursing.]

**[Occupational Therapy**

Services for medical care and treatment by an occupational therapist practicing in the scope of their license.]

**[Physician's Services**

- (1) Medical Care and Treatment.
- (2) Hospital, office and home visits.
- (3) Emergency room treatment services.
- (4) Surgery.
- (5) Services for surgical procedures.
- (6) Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of
  - (a) surgery to treat an Occupational Accidental injury that happens while You are covered under this Plan.
  - (b) Reconstructive surgery to remove scar tissue due to an Occupational Accidental injury that happens while You are covered under this Plan.

Assistant Surgeon Services are limited to 1/5 of the amount of Covered Expenses for the surgeon's charge for the surgery.

If You undergo more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- (1) For the second procedure, to [50%] of the Covered Expenses for the secondary procedure.
- (2) For any subsequent procedure, to [25%] of the Covered Expenses for the subsequent procedure.]

**[Physiotherapy**

When rendered by a Physician, as defined, for any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; limited to one visit per day.

**[Skilled Home Health Care**

Services given by a Home Health Care Agency. The following items are covered to the extent that they would have been covered under this benefit if You had stayed in the hospital.

- (1) Medical supplies.
- (2) Drugs and medications ordered by a Physician.
- (3) Laboratory services given or ordered by a hospital.

The care has to be ordered in writing and supervised by a Physician. [Payment for Skilled Home Health Care will be limited to the first 80 visits for each Occupational Accident.]]

**[Skilled Nursing Facility Charges**

Room and Board and Other Services and Supplies. Charges will be counted as Covered Expenses up to the facility's regular daily charge for a semi-private room. [Payment for Skilled Nursing Facility charges will be limited to the first 120 days of confinement for each Occupational Accident.] The care has to be supervised by a Physician. ]

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT**  
**(Continued)**

**[Speech Therapy**

Speech therapy given to restore speech. The speech must have been lost or impaired due to Occupational Accidental injury that happens while You are covered under this Plan.]

**[Not Covered**

- (1) Services or supplies that are not Medically Necessary, including any confinement, treatment, service or supply given in connection with a service or supply that is not Medically Necessary.
- (2) Care of and treatment to the teeth and gums is not covered except for those services specifically named in this benefit.
- (3) Eye glasses, eye refractions and hearing aids, unless required by an Occupational Accident that happens while covered.
- (4) Injury caused by war or international armed conflict.
- (5) Services given by any of the following persons:
  - (a) A member of Your immediate family; or who resides in Your home.
  - (b) Volunteers or persons who do not normally charge for their services.
- (6) Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- (7) Drugs, treatments, services or supplies that are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinement, treatment, service or supplies.
- (8) Cosmetic or reconstructive surgery or treatment (surgery or treatment primarily to change appearance) whether or not for psychological or emotional reasons. This exclusion does not apply to reconstructive surgery specifically named in the Plan.
- (9) Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - (a) Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
  - (b) Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.Care that meets one of the conditions above is custodial care regardless of any of the following:
  - (i) Who recommends, provides or directs the care.
  - (ii) Where the care is provided.
  - (iii) Whether or not the patient can be or is being trained to care for him or herself.
- (10) Treatment in a United States government or agency hospital. However, the reasonable cost incurred by the United States for medical care and treatment for a non-service connected disability given to a veteran by the United States or one of its agencies is covered to the extent the care and treatment is otherwise covered under the Plan. (This exclusion does not apply in Minnesota.)
- (11) Expenses for which You are not legally required to pay.(This exclusion does not apply to charges made by a hospital owned or operated by the states of Minnesota, Oregon or West Virginia.)
- (12) Private duty nursing services that is not Medically Necessary. In most cases, private duty nursing while confined in a Hospital is not Medically Necessary.

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT  
(Continued)**

- (13) Charges made by a Hospital for Room, Board or Other Fees during a confinement in an area of the Hospital that is used as a special care area, by whatever name called. A special care area is any area of a Hospital that renders services on an in-patient basis for other than acute care of sick or injured persons. Benefits for a covered facility that is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

Other exclusions that apply to this benefit are in **General Exclusions.**]

**GENERAL EXCLUSIONS**

In addition to the exclusions listed in specific benefit sections, this Plan does not cover any loss:

- (1) Covered by any workers' compensation, employers' liability, occupational disease or similar law.
- (2) Resulting from an intentionally self-inflicted injury.
- (3) Resulting from suicide or attempted suicide, while sane or insane (while sane in Missouri).
- (4) Resulting from boarding or alighting from any aircraft in motion.
- (5) Resulting from war or act of war; whether declared or not.
- (6) Resulting from duty in the armed forces of any country or international authority.
- (7) Resulting from the Insured being under the influence of any narcotic unless administered on the advice of a Physician and taken as prescribed, or being intoxicated as defined by the state where the Injury occurs.
- (8) That is psychological or emotional in nature, including pain and suffering.
- (9) Resulting from Cumulative Trauma (see Definitions), unless specifically shown as "Covered" in the Schedule of Benefits.
- (10) Resulting from Occupational Disease (see Definitions), unless specifically shown as "Covered" in the Schedule of Benefits.
- (11) To which a contributing cause was the commission of or attempt to commit a felony by the Insured whose injury or sickness is the basis of the claim, or to which a contributing cause was such person's being engaged in an illegal occupation or activity.

**NON-DUPLICATION OF WORKERS' COMPENSATION BENEFITS**

No benefits are payable under this Plan for any loss for which You claim benefits as an employee under any workers' compensation, occupational disease or similar law. If You claim benefits under this Plan and, at a later date, claim benefits for the same loss under any workers' compensation, occupational disease or similar law or benefit plan, We have the right to recover from You the amount of the benefits paid for such loss under this Plan.

## CLAIMS INFORMATION

### Assignment

This coverage may not be assigned. Benefit payments may be assigned at the time of claim. Any payment made by Us in good faith will end Our liability to the extent of the payment.

### Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to [Us at 5 Christopher Way, 3<sup>rd</sup> Floor, Eatontown, NJ 07724] [our Administrator at [address]] or to any authorized agent of Ours, with information sufficient to identify the insured Participant, shall be deemed notice to Us.

### Claim Forms

We, upon receipt of a written notice of claim, will furnish to the Participant such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished within 15 days after the giving of such notice the Insured shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### Proof of Loss

Written proof of loss must be furnished to Us, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one year from the time proof is otherwise required.

### Time of Payment of Claims

Indemnities payable under the Policy for any loss other than loss for which this policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy provides periodic payment will be paid and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

### Payment of Claims

Indemnity for loss of life will be payable in accordance with the Beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured . Any other accrued indemnities unpaid at the Insured's death may, at the option of the Insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured.

If any indemnity of this policy shall be payable to the estate of the Covered Person, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Insurer may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Insurer to be equitably entitled thereto. Any payment made by the Insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

## **CLAIMS INFORMATION (Continued)**

Subject to any written direction of the Insured in an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at the Insurer's option, and unless the Insured requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

### **Physical Examination and Autopsy**

We, at Our own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death, where it is not forbidden by law. (This provision does not apply to residents of Mississippi.)

### **Legal Actions**

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas; 6 years in South Carolina) after the time written proof of loss is required to be furnished.

### **Facility of Payment**

Whenever payments that should have been made under this Policy are made by any other policy, We shall have the right, exercisable at Our sole discretion, to pay over to any plan making such other payments any amounts We shall determine are warranted in order to satisfy the intent of this provision. The amounts so paid shall be considered benefits paid under this Policy and, to the extent of such payments, We shall be fully discharged from liability under this Policy.

### **Subrogation/Right of Recovery**

You must refund to Us any overpayment of benefits that occurs because a third party was liable to pay certain of Your expenses due to a wrongful act, negligence or omission. The refund will equal the amount We paid under this Plan. If the refund is due from another person or organization, You must help Us obtain the refund. We also have the right to pursue a refund or recovery even if You do not do so. This is called subrogation. You must help Us use this right when requested. The amount of the recovery will be reduced by a proper share of the legal fees and expenses needed to obtain the refund.

### **Claimant Cooperation Provision**

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

### **Fraud Warning**

Any person who knowingly, and with intent to defraud or deceive Us or any other person, makes a Request for Insurance or any claim for the proceeds of the Policy containing any false, incomplete or misleading information may be guilty of a crime. In New York, any person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

### **Conformity With State Law**

If any provision of the Policy or Certificate is in conflict with the laws in the state where it is issued it is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS REGARDING AN INDIVIDUAL'S COVERAGE

### Who Is Eligible For Coverage

Each person in one of the Eligible Classes shown in the Schedule of Benefits is eligible to be insured on the latest of:

- (1) the Policy Effective Date;
- (2) the Participant's Effective Date; or
- (3) the day after he or she completes the Eligibility Waiting Period, if later].

We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

### When Coverage Starts

Coverage under this Plan starts only after a Request for Insurance form is filed with and approved by Us and the required premium for coverage is paid.

### How to File a Request

Ask the Participant [(Owner/Operator if You are a Co-Driver, Helper or Contract Driver)] for a Request for Insurance form. It must be completed and filed with Us.

Coverage goes into effect on the latest of:

- (1) the Participant's Effective Date shown in the Schedule of Benefits.;
- (2) the date You are included in an Eligible Class and complete any Eligibility Waiting Period shown in the Schedule of Benefits.
- (3) the date We receive Your completed Request for Insurance form; or
- (4) the date the required premium is received by Us.

[If You are not working because You are disabled on the date coverage would start, coverage will not start until You are no longer disabled and return to work.]

### When Coverage Stops

Coverage will stop on the earliest of:

1. the date You are no longer in an Eligible Class;
2. the end of the period for which You paid premiums;
3. the date the Participant's coverage ends;
4. the date the Policy ends;
5. the date You attain the Age Limit shown in the Schedule of Benefits.

When Your coverage ends it will not affect a claim for a covered loss due to an Occupational Accident that happened while the coverage was in effect.

**Grace Period:** A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but You shall be liable to Us for the payment of the premium accruing for the period the policy continues in force. We may deduct from any claims otherwise payable any premium that is outstanding from the 31-day period.

### Benefits Available After Coverage Stops

#### Accidental Death and Dismemberment Benefits

We will pay these benefits if the loss happens within the Time Limit shown in the Schedule of Benefits after an Occupational Accident that occurs while You are covered under the Policy.

### **Disability Income Benefits**

If a Covered Person is Totally Disabled on the date coverage ends, We will pay benefits for that period of disability. Benefits will be paid for up to the Maximum Payment Period shown in the Schedule of Benefits, less the number of days paid before the date coverage stopped. Benefits will end earlier if the Covered Person is no longer Totally Disabled.

### **[Accident Medical/Dental Expense Benefits**

We will extend benefits under the Policy after a Covered Person's coverage would otherwise end if on that date he or she is under a Physician's care for a condition covered by the Policy for up to [90] days. Any benefits payable under this provision will not exceed the benefit maximums for this benefit shown in the Schedule of Benefits.]

## **DEFINITIONS**

### **[Appropriate Care**

The determination of an accurate and medically supported diagnosis of Your Total Disability, or ongoing medical treatment and care of Your disability by a Physician that conforms to generally-accepted medical standards, including frequency of treatment and care.]

### **[Average Weekly Earnings**

[Your prior year's taxable income or wages as reported for Federal Income Tax purposes, provided Your occupation was essentially the same as Your current occupation, divided by 52 or the number of weeks actually worked if less than 52.]

[Your average weekly earnings are the average payments made to You by the Participant or Covered Owner/Operator for work performed while transporting the Participant's cargo. Average weekly earnings will not include any performance bonus, expense reimbursement or other extra or additional payments of any kind. Average weekly earnings will be determined as the average of such payments over the shorter of:

- (1) The 104 weeks immediately prior to the date Total Disability began; or
- (2) The period worked.]

### **[Benefit Waiting Period**

The period of time You must be continuously Totally Disabled before disability income benefits may be payable. Your Benefit Waiting Period is shown in the Schedule of Benefits.]

### **[Co-Driver**

One of two drivers who take turns to drive a vehicle that is contracted to drive for the Participant. One of the drivers must be the insured Owner/Operator. All drivers must be legally licensed to drive the vehicle they are operating.]

### **[Contract Driver**

A driver who drives a power unit owned or leased by an Owner/Operator. A Contract Driver cannot be an employee of the Participant or the Owner/Operator.]

## **DEFINITIONS (Continued)**

### **[Covered Contract**

A long-term lease as defined by the U.S. Department of Transportation, Federal Motor Carrier Safety Administration. To be a "Covered Contract" such lease must meet all of the following:

- (1) It must be signed by both the Participant and the Owner/Operator.
- (2) The Owner/Operator must be responsible for:
  - (a) Power unit maintenance.
  - (b) Power unit operating costs, including but not limited to:
    - (i) Fuel.
    - (ii) Repairs
    - (iii) Physical damage insurance.
    - (iv) Personal expenses associated with the operation of the power unit.
- (3) The Owner/Operator must be compensated on a basis other than one based solely on time expended in performing work.
- (4) The Owner/Operator must have the responsibility for determining the time, means and method of performing the work.
- (5) The Owner/Operator must be an independent contractor. The Owner/Operator cannot be an employee of the Participant.

### **[Covered Person**

A person who is a member of an eligible class covered under this Policy as described in the Schedule of Benefits, for whom a request for insurance is received and appropriate premium has been paid when due and coverage is still in force.]

### **[Cumulative Trauma**

An injury diagnosed by a Physician as occurring without sudden cause or result. Cumulative Trauma includes injury caused by continual stress and strain. Such injury may be causally related to Your job. Such injury may be due to repetitive traumatic acts.]

### **[Health Care Plan**

Any plan providing medical expense benefits by:

- (1) any type of service plan contract, any group or blanket insurance, Independent Contractor benefit plan or any plan arranged through an employer, trustee, union or Independent Contractor benefit association;
- (2) Medicare or Medicaid; or
- (3) Any plan or program created or administered by the federal or state government or their agencies.]

### **[Home Health Care Agency**

An agency or organization that is either:

- (1) Approved under Medicare.
- (2) Established and operated in accordance with the applicable licensing and other laws.]

### **[Hospital**

An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and that fully meets one of the following tests:

- (1) It is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.
- (2) It is approved by Medicare as a hospital.]

**[DEFINITIONS  
(Continued**

**[Immediate Family**

Means You: wife or husband; In-laws; brother or sister; step-brother or step-sister; parent or step-parent; or child.]

**[Injury**

Means bodily harm which results, directly and independently of disease or bodily infirmity, from an Occupational Accident. All injuries to the same insured person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.]

**[Insured**

A member of an eligible class covered under this Policy as described in the Schedule of Benefits, for whom request for insurance is received and appropriate premium has been paid when due.]

**[Laborer**

An individual engaged by the Owner/Operator to handle manual tasks in regard to loading, unloading or otherwise assisting in the duties that the Owner/Operator has contracted to handle for the Participant. The laborer must not be an employee of the Participant and the Owner/Operator must submit the request for insurance on behalf of the laborer and the required premium must be paid. ]

**[Medical Emergency**

A condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.]

**[Medically Necessary**

We determine, in Our discretion, if a service or supply is medically necessary for the diagnosis and treatment of an Occupational Accidental injury. This determination is based on and consistent with standards approved by Our medical personnel. These standards are developed, in part, with consideration to whether the service or supply meets the following:

- (1) It is appropriate and required for the diagnosis or treatment of the Occupational Accidental injury
- (2) It is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- (3) There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the service or supply given.

A determination that a service or supply is not medically necessary may apply to the entire service or supply or to any part of the service or supply.]

**[Occupational Accident**

A sudden, unforeseen event, or series of events that are work related and that result in bodily injury within [72 hours] of the date of the event. This event must meet all of the following:

- (1) It must happen while You are Under Contract with the Participant and performing Your contract obligations under that contract.
- (2) It must happen while You are covered under this Plan.
- (3) The bodily injury must result directly from the Occupational Accident and not be the result of any other cause.

## **DEFINITIONS (Continued)**

"Occupational Accident" **does not** include any of the following:

- (1) Aggression in a fight.
- (2) Hernia of any type, unless specifically covered by this Plan.
- (3) Suicide or attempted suicide.
- (4) Cumulative Trauma, unless specifically covered by this Plan.
- (5) Occupational Disease, unless specifically covered by this Plan.]

### **[Occupational Disease**

A disease that:

- (1) Is not traceable to a specific Occupational Accident; and
- (2) Is caused by exposure to a disease producing agent present in Your occupational environment.]

### **[Other Income Benefits**

Other Income Benefits include any amounts that You or Your dependents receive (or are assumed to receive) under:

- (1) any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.
- (2) any Social Security or retirement benefits You receive or any third party receives (or is assumed to receive) on Your behalf or for Your dependents; or, if applicable, that Your dependents receive (or are assumed to receive) because of Your entitlement to such benefits.
- (3) Any proceeds payable under any group insurance or similar plan. If there is other insurance that applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, We will pay our pro rata share of the total claim.

"Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.]

### **[Other Services and Supplies**

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).]

### **[Owner/Operator**

A person who meets all of the following tests:

- (1) They are an Independent Contractor as defined by law.
- (2) They are not an employee of the Participant.
- (3) They have entered into a Covered Contract with the Participant for the leasing of the Owner/Operator's power unit.
- (4) They do not own or control the Participant.
- (5) They are compensated on a Form 1099 and not a Form W-2.

A Co-owner of a power unit will be considered an Owner/Operator as long as the Co-owner meets all of the above tests.]

### **[Participant**

Any entity or organization that has signed a Participation Agreement with the Policyholder and subscribes to the coverage provided by this Policy.]

## **DEFINITIONS (Continued)**

### **[Physician**

A licensed practitioner of the healing arts. The practitioner must be legally qualified to render the service being provided and not a member of the Covered Person's family or household.]

### **[Policy**

A legal contract between the Policyholder and Us, describing the terms and conditions of this coverage subject to any provisions, limitations, and exclusions.]

### **[Policyholder**

An entity to which We issue this Policy. The Policyholder is named on page 1.]

### **[Reasonable Charge**

An amount measured and determined by Us by comparing the actual charge for the service or supply with the prevailing charges made for it. We determine the prevailing charge. It takes into account all pertinent factors including:

- (1) The complexity of the service.
- (2) The range of services provided.
- (3) The prevailing charge levels in the geographic area where the provider is located and other geographic areas having similar medical cost experience.]

### **[Room and Board**

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.]

### **[Schedule of Benefits**

A section of the Certificate briefly outlining the coverage and benefits provided by the Policy.]

### **[Skilled Nursing Facility**

An institution that fully meets one of the following tests:

- (1) It is approved by Medicare as a Skilled Nursing Facility.
- (2) If not approved by Medicare, the facility must be operated under the applicable licensing and other laws of the jurisdiction where it is located.

It cannot be, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, or a home for alcoholics or drug addicts or the mentally ill.]

### **[Total Disability**

[For the first [26] [52] [104] [156] [208] weeks of Total Disability], Your inability to perform all of the substantial and material duties of Your regular employment or occupation [and earning less than 80% of your pre-disability earnings].

[For any period of Total Disability continuing for more than [26] [52] [104] [156] [208] weeks], You must meet both of the following:

- (1) You cannot be engaged in any work for pay or profit.
- (2) You must be unable to perform all the substantial and material duties of **any** occupation or employment that You are qualified for by reason of education, training or experience.]

**DEFINITIONS**  
**(Continued)**

**[Under Contract**

A Covered Owner/Operator while performing all the regular duties required by the Covered Contract with the Participating Organization. Under Contract also means for a covered member of an Eligible Class other than an Owner/Operator, performing the duties contracted with the Owner/Operator. . This includes traveling to and from the place of business and the location where these duties are performed, and where Your equipment receives routine scheduled maintenance.]

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### COMA BENEFIT RIDER

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Coma Benefit.** If Injury renders an Insured Person Comatose within the Incurral Period shown below. The Incurral Period is the time measured from the date of the accident that caused such Injury. If the Coma continues for a period of 30 consecutive days, the Company will pay a monthly benefit equal to 1% of the Principal Sum shown below. No benefit is provided for the first 30 days of the Coma. The benefit is payable monthly as long as the Insured Person remains Comatose due to that Injury but ceases on the earliest of:

- (1) the date the Insured Person ceases to be Comatose due to that Injury; or
- (2) The date the Insured Person dies; or
- (3) The date the total amount of monthly Coma benefits paid for all Injuries caused by the same accidents equals the Principal Sum shown below.

The Company will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which the Company is liable when the Insured Person is Comatose for less than a full month. Only one benefit is provided for any one month of Coma, regardless of the number of Injuries causing the Coma.

The Company reserves the right, at the end of the first 30 consecutive days of Coma and as often as it may reasonable require thereafter, to determine, on the basis of all facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at the expense of the Company.

Coma/Comatose- as used in this Rider, means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician.

Incurral Period: [4 to 156] weeks

Principal Sum: [\$10,000]

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Signature



Signature



Douglas M. Libby  
Chairman and CEO

James Kraus  
Secretary

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### DEPENDENT COVERAGE RIDER

Effective Date: \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**I. Dependents Coverage.** [(Not Applicable to Class 4 - Scheduled Laborers)]

**A. [Schedule of Benefits**

- 1 Your Dependent's Accident Medical/Dental Expense Benefits are payable [to the same extent these] [at [50%] of the] benefits [that] are payable for You.
- 2 Your Dependent's Principal Sum is shown on the Schedule of Benefits:
  - a. [For your covered Spouse:[50% of Your] Principal Sum]
  - b. [For your covered Dependent Child(ren): [20% of Your] Principal Sum]

**B. Eligibility:** Your Dependents are eligible on the date:

1. You are eligible, if You have a Dependent on that date; or
2. the date You acquire a Dependent, if later.

In no event will a Dependent be eligible if You are not insured for both Occupational Accident and Non-Occupational Accident Coverage under the Policy.

["Spouse" means Your lawful spouse or registered domestic partner, if required by law in your state, who is under age 65 and is not legally separated or divorced from You.]

["Dependent Child" means an Insured's or Insured's spouse's unmarried child to age 26. Insurance will continue for any Dependent child who reaches the age limit and is and continues to be both: (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to the attainment of 26 years of age, and (b) chiefly dependent upon the Insured or Insured's spouse for support and maintenance. The Insured or Insured's spouse must send Us satisfactory proof of the incapacity and dependency. If the incapacity or dependency is later removed or terminated, You must notify Us of the change.]

[A Dependent child is automatically covered from the moment of birth until such child is 90 days old if all other eligible children are covered under the certificate prior to the birth of the child. The Insured must notify Us in writing within 90 days of such birth or before the next premium due date, whichever is later, and pay the required additional premium (if any), in order to have coverage for the child continue beyond such 90 day period. An adopted child is automatically covered for the first 60 days from the date of the Insured filing a petition for adoption unless the petition is denied or dismissed. The Insured must notify Us in writing within 60 days of filing the petition for adoption and pay the required additional premium (if any) in order to have coverage for the adopted child continue beyond such 60 day period.]

- C. Effective Date:** Insurance for Your Dependent who is named on Your Request for Insurance is effective on the latest of the following dates:
1. Your Effective Date;
  2. the date We receive the completed Request for Insurance for the Dependent, and the required premium for the Dependent is paid.
- D. [Deferred Effective Date:** If Your Dependent is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service. "Active Service" means Your Dependent, if employed, is performing all regular duties of his or her job on a full-time basis; or if not employed, is able to engage in substantially all of the usual activities of a person in of like age and gender and not confined in a Hospital or rehabilitation or rest facility. Your Dependent's insurance will not be in effect prior to Your effective date.]
- E. Termination Date Of Insurance:** Your Dependent's coverage will end on the earliest of the date:
1. Your coverage ends;
  2. the period ends for which premium is paid; or
  4. the date he or she is no longer a Dependent as defined herein.

**II. Benefits**

- A.** [Benefits are payable for Accidental Death and Dismemberment and Accident Medical/Dental Expense Benefits as shown in the Schedule of Benefits.]
- B.** [The Principal Sum that applies to Your Dependent(s) is shown in the Schedule of Benefits.]
- C.** No Disability Income Benefits are payable for Your Dependent's Total Disability.
- D.** [Unless otherwise agreed to by Us, all benefits for Your Dependent's Loss of Life will be paid to You [in [monthly] installments.]

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Signature



Douglas M. Libby  
Chairman and CEO

Signature



James Kraus  
Secretary

# UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## EMERGENCY EVACUATION BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Emergency Evacuation Benefit.** The company will pay, subject to the limitation set out herein, for Covered Emergency Evacuation Expenses reasonably incurred if the Insured Person suffers an Occupational Injury that warrants Emergency Evacuation while outside a 100 mile radius from the Insured's current place of primary residence, but not exceeding the Maximum Benefit Amount shown below per Insured Person for all Emergency Evacuations due to all Injuries from the same accident.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured Person's Injury warrants his or her Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

The Occupational Accident Claims Department of your Insurance Company must make all arrangements and must authorize all expenses in advance for any Emergency Evacuation benefits to be payable. You may report your claim to an authorized claim representative at [1-800-XXX-XXXX]. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact the Occupational Accident Claims Department of your Insurance Company in advance.

Covered Emergency Evacuation Expense(s) – as used in this Rider, means an expense that:

- (1) is charged for a Medically Necessary Emergency Evacuation Service;
- (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and
- (3) does not include charges that would not have been made if no insurance existed.

**Emergency Evacuation** – as used in this Rider, means, if warranted by the severity of the Insured Person's Injury:

- (1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury to the nearest hospital or other medical facility where appropriate medical treatment can be obtained;
- (2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a hospital or other medical facility or to recover after suffering an Injury and being treated at a local hospital or other medical facility; or
- (3) both (1) and (2) above.

An Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

**Medically Necessary Emergency Evacuation Service** – as used in this Rider, means any Transportation, medical treatment, medical service or medical supply that:

(1) is an essential part of an Emergency Evacuation due to the Injury for which it is prescribed or performed; and

(2) meets generally accepted standards of medical practice; and

(3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Insured Person.

**Transportation** – as used in this Rider, means moving the Insured Person during an Emergency Evacuation by land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

**Emergency Evacuation Maximum Benefit:** [\$10,000]

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### FELONIOUS ASSAULT BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Felonious Assault Benefit.** The Company will pay the Maximum Benefit Amount shown below when the Insured Person suffers one or more losses for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, Temporary Total Disability Benefit or Continuous Total Disability Benefit provided by the Policy as a result of a Felonious Assault;

1. that is directed at the Policyholder or Certificateholder, their property or assets, or an Insured Person while he or she is performing Occupational services; and
2. that is not a moving violation as defined under the applicable state motor vehicle laws; and
3. that is not an act of a member, employee or representative of the Policyholder or Certificateholder, or an individual who is under contract to perform Occupational services.

Only one benefit is payable under this Rider for all losses as a result of the same Felonious Assault.

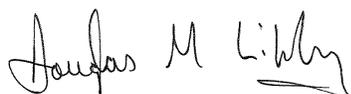
**Felonious Assault-** as used in this Rider means any willful or unlawful use of force upon the Insured Person:

1. with the intent to cause bodily injury to the Insured Person; and
2. that results in bodily harm to the Insured Person; and
3. That is a felony or a misdemeanor in the jurisdiction in which it occurs.

**Felonious Assault Maximum Benefit: [\$10,000]**

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary



# UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## HEMORRHOID BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Hemorrhoids Coverage.** Benefits are payable for the following benefit(s) only: Accident Medical Expense and Temporary Total Disability.

Accident Medical Expense and Temporary Total Disability Benefits shall be payable for the Insured Person's Hemorrhoids sustained as a result of Occupational activities, provided such Hemorrhoids are sustained and surgically repaired while the Insured Person's coverage is in force under this Policy, subject to the following:

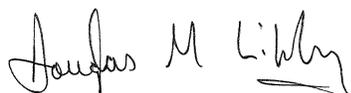
1. With respect to the Accident Medical Expense Benefit, benefits payable for or in connection with the Insured Person's Hemorrhoids, subject to the Accident Medical Expense Deductible Amount, if any, shall not exceed the applicable Maximum Benefit Amount shown below.
2. With respect to the Temporary Total Disability Benefit, the period for which such indemnity shall be payable for all periods of disability, subject to the Temporary Total Disability Benefit Waiting Period, shall not exceed the applicable Lifetime Maximum Benefit Period or Amount shown below.

**Hemorrhoid (s)** - as used in this Rider, means a mass of dilated veins in swollen tissue at the margin of the anus or nearby within the rectum.

**Lifetime Maximum Benefit Amount for All Benefits:** [\$5,000]

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

**UNITED STATES FIRE INSURANCE COMPANY**

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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**HERNIA BENEFIT RIDER**

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Hernia Coverage.** Benefits are provided for Hernia only for: Accident Medical Expense and Temporary Total Disability .

Accident Medical Expense and Temporary Total Disability benefits shall be payable for the Insured Person's Hernia, provided such Hernia is sustained as a result of Occupational activities, and is sustained and surgically repaired while the Insured Person's coverage is in force under this Policy, subject to the following:

1. With respect to the Accident Medical Expense Benefit, benefits payable for or in connection with the Insured Person's Hernia, subject to the Accident Medical Expense Deductible Amount, if any, shall not exceed either the applicable Hernia, per Injury Limit or applicable Lifetime Maximum Benefit Amount or Period shown below.

2. With respect to the Temporary Total Disability Benefit, the period for which such indemnity shall be payable for all periods of disability, subject to the Temporary Total Disability Benefit Waiting Period, shall not exceed either the applicable Hernia Injury or Lifetime Maximum Benefit Amount or Period shown below.

**Hernia** - as used in this Rider, means a protrusion of an organ or part through connective tissue or through a wall of the cavity in which it is normally enclosed. Hernia does not include diaphragmatic (hiatal) hernia.

**Maximum Hernia Injury Benefit:** **[\$5,000]**  
**Lifetime Maximum Hernia Injury Benefit:** **[\$10,000]**

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

**SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:**



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

# UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## HIJACKING BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Hijacking Benefit.** The Company will pay the Maximum Benefit Amount shown below under this Rider with the Insured Person suffers an Injury for which benefits are payable under the Accidental Death Benefit or Accidental Dismemberment Benefit provided by the Policy as a result of a Hijacking of a tractor-trailer vehicle while the Insured Person is operating or riding as a passenger in and including getting in to or out of such vehicle and performing his or her Occupational duties.

Only one benefit is payable under this Rider for all losses as a result of the same Hijacking.

Verification of the Hijacking must be part of an official policy report of the Hijacking or be certified, in writing, by the investigating officer(s).

**Hijacking** – as used in this Rider, means taking unlawful possession of a Motor Vehicle by means of force or threats against the person(s) then rightfully occupying such Motor Vehicle.

**Hijacking Maximum Benefit Amount: [\$5,000]**

**Lifetime Maximum Hijacking Benefit Amount: [\$10,000]**

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Home Alteration and Vehicle Modification Benefit.** If an Insured Person:

1. suffers an Injury for which an Accidental Dismemberment Benefit is payable under the Policy;
2. did not, prior to the date of the accident causing such Injury require the use of a wheelchair to be ambulatory; and
3. as a direct result of such Injury is now required to use a wheelchair to be ambulatory;

Benefits will be payable for covered Home alteration and Vehicle Modification Expenses that are incurred within one year after the date of the accident causing Injury, up to the Maximum Benefit amount shown below for all losses caused by the same accident.

A Covered Home Alteration and Vehicle Modification Expenses, as used in this rider, means one-time expenses that:

1. are charged for:
  - a. alterations to the Insured person's residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person; or
  - b. modifications to a motor vehicle owned or leased by the Insured Person to modification to a motor vehicle newly purchase for the Insured Person that are necessary to make the vehicle accessible to and/or drivable by the Insured Person; and
2. do not include charges that would not have been made if no insurance existed; and
3. do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred;
4. and are only if the alterations to the Insured Persons residence and the modifications to his or her motor vehicle are;
  - a) made on behalf of the Insured Person;
  - b) recommended by a nationally-recognized organization providing support and assistance to wheelchair users;
  - c) 3. carried out by individuals experienced in such alterations and modifications; and

- d) 4. in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

Maximum Benefit for Alteration and Vehicle Modification Expenses: [\$5,000].

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR **THE UNITED STATES FIRE INSURANCE COMPANY** BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

**UNITED STATES FIRE INSURANCE COMPANY**

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

**IN-HOSPITAL INDEMNITY BENEFIT RIDER**

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**In-Hospital Indemnity Benefit.** If an Insured Person suffers an Injury that, within the Incurral Period shown below, requires the Insured to be confined in a Hospital as an Inpatient, We will pay a benefit after satisfaction of the Waiting Period shown below retroactive to the first Day of Confinement. The amount of the benefit is equal to the Daily Maximum Amount shown below per day of inpatient confinement due to that injury. It is payable not less frequently than monthly up to the Maximum Benefit Period shown in the Schedule during any one Period of Confinement. Only one benefit is provided for any one Day of Confinement, regardless of the number of Injuries for which the confinement is required. In no event will the maximum amount payable in an Insured Person's lifetime with respect to the In-Hospital Indemnity Benefit exceed the Lifetime Maximum Benefit Amount shown below.

Day(s) of Confinement – as used in this Rider, means a day of Hospital confinement as an Inpatient.

Inpatient – as used in this Rider, means an Insured:

- 1. who is confined in a Hospital as a registered bed patient; and
- 2. for whom at least one day's room and board is charged by the Hospital .

**Period of Confinement** –a as used in this Rider, means a period of consecutive Days of Confinement as an Inpatient for all Injuries caused by the same Accident. However, successive confinements as an Inpatient for all Injuries caused by the same Accident are considered to be part of the same Period of Confinement, unless the discharge date for the prior confinement is separated for the admission date for the next confinement by at least 60 days.

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

Incurral Period:	[4 to 156] weeks
Waiting Period:	[7 to 14] days
Daily Maximum Benefit:	[\$100]
Maximum Number Days Per Injury:	[10]
Lifetime Maximum Benefit:	[\$5,000]

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Douglas M. Libby  
Chairman and CEO

James Kraus  
Secretary

**APPLICATION**

Is made to

**UNITED STATES FIRE INSURANCE COMPANY**

Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

**APPLICATION IS MADE BY:** Marine Bank, Trustee for The Group and Blanket Accident & Health Insurance Trust

**FOR GROUP POLICY:** OCCUPATIONAL ACCIDENT POLICY

**POLICY NUMBER:** AH27700-006

On behalf of The Group and Blanket Accident & Health Insurance Trust, we hereby apply to United States Fire Insurance Company for insurance coverage under the above referenced Group Policy. By signing below, we hereby accept the terms and approve the issuance of this Group Policy, for which we will become the Policyholder. Coverage under this Group Policy will take effect on the date specified in the Schedule of the Group Policy.

**Fraud Warning: Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim that contains a false or deceptive statement, or conceals information for the purpose of misleading, may be guilty of insurance fraud and subject to criminal and/or civil penalties.**

**Signed In:** \_\_\_\_\_ on \_\_\_\_\_  
(City, State) (Date)

**Signature:** \_\_\_\_\_  
**Authorized Representative for Policyholder**

\_\_\_\_\_  
(Printed Name) (Title)

**Signature of Witness:** \_\_\_\_\_

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### NATURAL DISASTER BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Natural Disaster Benefit.** We will pay the Maximum Benefit Amount shown below under this Rider when the Insured Person suffers one or more losses as a result of an Injury that occurs in a declared disaster area and for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, provided by the Policy as a direct result of a Natural Disaster.

Natural Disaster – as used in this Rider, means a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or similar event that;

1. is due to natural causes; and
2. results in such severe and widespread damage that the area of damage is officially declared a disaster area by a government having authority to make such a declaration.

Maximum Benefit Amount:       [\$5,000]

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

**UNITED STATES FIRE INSURANCE COMPANY**  
Administrative Office: 5 Christopher Way • Eatontown, NJ 07724

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**PARTICIPATION AGREEMENT**

The undersigned Organization is hereby applying to UNITED STATES FIRE INSURANCE COMPANY to participate in THE GROUP AND BLANKET ACCIDENT & HEALTH INSURANCE TRUST. Such participation entitles the Organization to coverage for its Independent Contractors under the said Trust. The Applicant also agrees to be bound by all of the terms of the Trust Agreement and the Insurance Policy and further understands and agrees that:

1. This request to participate does not assure acceptance as a Participant under the Trust.
2. Neither this request to participate, nor the payment of any monies to be applied toward the premium, shall cause insurance coverage to become effective on any person. In order for coverage to take effect: (a) the Applicant must be accepted as a Participant; and (b) each Independent Contractor must satisfy the eligibility requirements of the policy.
3. The Applicant has seen a copy of the benefits proposed and agrees to give all eligible persons an opportunity to enroll for the insurance.
4. The insurance is subject in every respect to the group policy which alone constitutes the agreement under which benefits are paid.

Acceptance of this request is subject to all of United States Fire Insurance Company's requirements and terms of the group policy issued to the Trustee. United States Fire Insurance Company will notify the Applicant in writing of any approval or disapproval of this request. A notice of approval will specify the effective date of the Participant's plan or plan change. If the Applicant is accepted as a Participant, it will receive a benefit plan description.

The Applicant requests participation in THE GROUP AND BLANKET ACCIDENT & HEALTH INSURANCE TRUST, Effective [November 1, 2010] and agrees to be bound by its terms.

**Fraud Warning: Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.**

**SIGNED FOR THE ORGANIZATION:**

IN \_\_\_\_\_, \_\_\_\_\_ THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.  
(City) (State)

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Signature of Authorized Person

Printed Name

Title

# UNITED STATES FIRE INSURANCE COMPANY

(Herein Called "We, "Our", Or "Us")

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## Occupational Accident Policy

**POLICYHOLDER:** [The Group and Blanket Accident & Health Insurance Trust]

**POLICY NUMBER:** [AH27700-006]

**POLICY EFFECTIVE DATE:** [December 1, 2010]

**{POLICY ANNIVERSARY DATE:** [December 1]

**STATE OF DELIVERY:** [Illinois]

This Policy describes the terms and conditions of coverage for Occupational Accident Insurance. The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above.

This Policy is governed by the laws of the state in which it is delivered.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Signature



Douglas M. Libby  
Chairman and CEO

Signature



James Kraus  
Secretary

### IMPORTANT NOTICE

**THIS IS A CERTIFICATE FOR OCCUPATIONAL ACCIDENT BENEFITS ONLY. BENEFITS ARE NOT PAID FOR SICKNESS OR ANY OTHER TYPE OF INJURY. THIS POLICY IS NOT WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

**This Policy is Accident Only Insurance. It does not pay any benefits for Sickness.**

**This Policy may be discontinued by the Insurance Company according to the terms of the Policy.**

**Non-Participating Insurance**

## GENERAL POLICY PROVISIONS

**Entire Contract:** The Policy (including any endorsements or amendments), the signed application of the Policyholder or Participant, and any individual applications of Covered Persons, constitute the entire contract between the parties, and any statement made by the Policyholder or Participant shall, in the absence or fraud, be deemed a representation and not a warranty. No statement made by any Covered Person whose eligibility has been accepted by Us shall void the insurance or reduce the benefits under this policy or be used in defense to a claim hereunder in the absence of fraud.

**Changes:** To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

**Incontestability:** (1) After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the Policy, by the Participant in the Participation Agreement or by the Insured in the Request for Insurance, shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2 year period.

**Clerical Error:** If a clerical error is made, it will not affect the insurance of any Covered Person. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

**Termination of the Policy:** Either the Policyholder or We may end this Policy at any time by providing the other party with written or authorized electronic or telephonic notice. If We end this Policy, it will be effective on the later of: 1) the date stated in the notice; or 2) [10] days after We deliver the notice. If the Policyholder ends this Policy, it will be effective on the later of: 1) the date We receive the notice; or 2) the date stated in the notice.

**Examination Of Records And Audit:** We shall be permitted to examine and audit the Participant's books and records at any time during the term of the Policy and within 2 years after the final termination of the Participant's coverage as they relate to the premiums or subject matter of this insurance.

**Certificates Of Insurance:** Where it is required by law, or upon the request of the Participant, We will make available certificates outlining the insurance coverage and to whom benefits are payable under the Policy.

**Participation:** A Participant is eligible for coverage of those persons in the Eligible Classes shown on the Schedule of Benefits on the later of: 1) the Policy Effective Date; or 2) the Participant's Effective Date, or the date the person in the Eligible Class submits the Request for Coverage and pays the required premium.

**Renewal:** Subject to Our consent, a Participant's coverage may be renewed on each Participation Anniversary Date. We have the right to refuse to renew a Participant's coverage on any Anniversary Date. If we refuse to renew coverage under the Policy, We will provide at least {31 days} advanced written or authorized electronic or telephonic notice of Our intent to not renew.

**Cancellation of Participation:** The Participant may end their Participation in the Policy by giving Us written or authorized electronic or telephonic notice and the Participant agrees to give notice of termination to all Covered Persons under their Participation agreement 30 days prior to such termination

We may cancel Participation in this policy at any time by written notice delivered to the Participant, or mailed to his last address as shown on Our records, stating when, not less than [31] days thereafter, such cancellation shall be effective.

**Premium Rates:** The initial premium rates for insurance under this Policy will be based on the schedule of premium rates agreed to by the Policyholder and Us. We may change rates from time to time with at least [31] days advanced written or authorized electronic or telephonic notice. [For Pennsylvania and Louisiana Participants no change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a [12] month period. We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

**[Experience Rating:** This Policy is subject to experience rating. This means that We may reduce the premium rates at the end of any policy year due to good experience. We may not increase the premium rates for any policy year due to poor experience in that year.]

**Premium Due Date:** The first Premium is due on the Participant's Effective Date. Coverage will not go into effect unless this first premium is paid in full by that date. After that, premiums will be due monthly in advance unless We agree with the Participant on some other method of premium payment. Premiums are payable to Us or Our authorized agent by the Premium Due Date shown in the Schedule of Benefits.

If any premium is not paid when due, participation under the Policy will be canceled as of the last day of the period for which premiums were paid, except as provided in the Grace Period provision.

**Grace Period:** A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the Policyholder or Participant shall be liable to Us for the payment of the premium accruing for the period the policy continues in force.

**Records To Be Kept By The Participant:** The Participant will keep a record of: 1) each person who is covered under the Policy; and 2) each person's beneficiary, if one is needed. We have the right to see the Participant's records. We have the right to audit or inspect these records at any reasonable time to determine who is insured and for any other purpose relating to this insurance.

**THE REMAINDER OF THIS POLICY CONTRACT CONSISTS OF THE  
CERTIFICATE, AND ANY ENDORSEMENT  
WHICH IS ATTACHED TO, AND IS MADE A PART OF,  
THIS GROUP POLICY.**

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### REHABILITATION BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Rehabilitation Benefit.** If an Insured Person suffers an Injury for which an Accidental Dismemberment, is payable under the Policy, the Company will reimburse the Insured Person for Covered Rehabilitative Expenses that are incurred due to the Injury causing the dismemberment up to the Maximum Benefit Amount shown in the Schedule for all Injuries caused by the same accident. The Covered Rehabilitative Expenses must be incurred within two years after the date of the accident causing that Injury.

**Covered Rehabilitative Expense(s)** – as used in this Rider, means an expense that:

1. Is charged for a Medically Necessary Rehabilitative Training Service of the Insured Person performed under the care, supervision or order of a Physician; and
2. does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a Hospital room and board charge, does not exceed the most common charge for Hospital semi-private room and board in the Hospital where the expense is incurred); and does not include charges that would not have been made if no insurance existed.

**Hospital** as used in this Rider, means a facility that is operated according to law for the care and treatment of injured and sick people;

1. has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
2. has 24 hour nursing service by registered nurses (RN), on duty or on call; and
3. is supervised by one or more Physicians.

**A Hospital does not include:**

1. a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care;
2. a facility that is, other than incidentally, a rest home nursing home convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or
3. any military or veteran's hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

**Medically Necessary Rehabilitative Training** Service as used in this Rider, means any medical service, medical supply, medical treatment or hospital confinement (or part of a Hospital confinement) that:

1. is essential for physical rehabilitative training for the Injury for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a Physician.

**EXCLUSIONS** – In addition to the Exclusions in the Exclusions section of the Policy and in any amendment thereto, Covered Rehabilitative Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under the Accidental Medical Expense Benefit.

**Maximum Benefit Per Injury: [\$5,000]**

**Lifetime Maximum Benefit: [\$10,000]**

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary



**OWNER/OPERATOR  
REQUEST FOR INSURANCE**

United States Fire Insurance Company

Under Group Policy Number AH2700-[006], issued to the Trustee of the Group and Blanket Accident & Health Insurance Trust.

Participant: \_\_\_\_\_  
(Name and Address)

Owner/Operator: \_\_\_\_\_  
(Name and Address)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of Owner/Operator)

**By signing this Request for Insurance the Owner/Operator agrees to all of the following:**

- 1. To be covered under the above specified Group Policy.
- 2. To request coverage for the persons listed below:
  - Owner/Operator  Scheduled Contract Driver of Owner/Operator
  - Scheduled Co-Driver  Scheduled Laborer

The wife or husband of an Owner/Operator, Scheduled Co-Driver or Scheduled Contract Driver will be covered only if the Owner/Operator, Scheduled Co-Driver or Scheduled Contract Driver is listed in the Schedule below and Spouse Coverage is shown as "Yes". Spouse coverage is not available to the Scheduled Laborer.

- 3. To make to the Motor Carrier such payments as may be required for the insurance to be provided in the manner specified by the Motor Carrier.
- 4. That all of the statements made in this Request are, to the best of my knowledge and belief, true and accurate.

**EFFECTIVE DATE OF INSURANCE-** The Effective Date of Insurance is the date shown in the Schedule of Benefits in each person's Certificate of Insurance provided this request has been approved by ABC Insurance Company and its Underwriting Manager specified below, and the proper premium has been paid.

**AMOUNTS OF INSURANCE REQUESTED (Applies only to persons specified above)**

**Owner/Operator**

**Accidental Death & Dismemberment Benefit**

Principal Sum-  \$10,000  \$25,000  \$50,000  \$100,000

**Disability Income Benefit - Maximum Benefit**

Temporary Disability- Weekly Benefit -  \$300  \$400  \$500

The amount of Weekly Benefit cannot exceed [70%] of a person's Average Weekly Earnings, [minus any Other Income Benefits].

Permanent Total Disability-Monthly Benefit- 4.3 times Average Weekly Earnings\* times[ 0.70], subject to a maximum amount of \$1,505 per month [minus any Other Income Benefits.]

**Accident Medical/Dental Benefit-Maximum Benefit-**  \$100,000  \$150,000  \$200,000

**Scheduled Co-Driver**

**Accidental Death & Dismemberment Benefit**

Principal Sum-  \$10,000  \$25,000  \$50,000  \$100,000

**Disability Income Benefit - Maximum Benefit**

Temporary Disability- Weekly Benefit -  \$300  \$400  \$500

The amount of Weekly Benefit cannot exceed [70%] of a person's Average Weekly Earnings [minus any Other Income Benefits].

Permanent Total Disability-Monthly Benefit- 4.3 times Average Weekly Earnings\* times[ 0.70], subject to a maximum amount of \$1,505 per month [minus any Other Income Benefits.]

**Accident Medical/Dental Benefit-Maximum Benefit-**  \$100,000  \$150,000  \$200,000

**Scheduled Contract Driver**

**Accidental Death & Dismemberment Benefit**

Principal Sum-  \$10,000  \$25,000  \$50,000  \$100,000

**Disability Income Benefit - Maximum Benefit**

Temporary Disability- Weekly Benefit -  \$300  \$400  \$500

The amount of Weekly Benefit cannot exceed [70%] of a person's Average Weekly Earnings [minus any Other Income Benefits].

Permanent Total Disability-Monthly Benefit- 4.3 times Average Weekly Earnings\* times[ 0.70], subject to a maximum amount of \$1,505 per month [minus any Other Income Benefits.]

**Accident Medical/Dental Benefit-Maximum Benefit-**  \$100,000  \$150,000  \$200,000

**Scheduled Laborer**

**Accidental Death & Dismemberment Benefit**

Principal Sum-  \$10,000  \$25,000  \$50,000  \$100,000

**Disability Income Benefit - Maximum Benefit**

Temporary Disability- Weekly Benefit -  \$300  \$400  \$500

The amount of Weekly Benefit cannot exceed [70%] of a person's Average Weekly Earnings [minus any Other Income Benefits].

Permanent Total Disability-Monthly Benefit- 4.3 times Average Weekly Earnings\* times[ 0.70], subject to a maximum amount of \$1,505 per month [minus any Other Income Benefits.]

**Accident Medical/Dental Benefit-Maximum Benefit-**  \$100,000  \$150,000  \$200,000

**Spouse Coverage**  Yes  No (The Owner/Operator must elect to provide this coverage) (Spouse coverage is not available to Scheduled Laborer)

**Accidental Death & Dismemberment Benefit-Principal Sum-**[50% of the amount shown above.]

**Disability Income Benefit-** None

**Accident Medical/Dental Benefit-Maximum Benefit-**same as the amount for Accident/Medical Dental specified above.

**Optional Riders**

**Non-Occupational Coverage Rider**  Yes  No

**Passenger Coverage Rider**  Yes  No

**Owner/Operator**

Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
*(To be filled in ONLY if Spouse coverage has been elected)*

**Scheduled Co-Driver(s)**

1. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
*(To be filled in ONLY if Spouse coverage has been elected)*

2. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
*(To be filled in ONLY if Spouse coverage has been elected)*

**Scheduled Contract Driver(s)**

1. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
*(To be filled in ONLY if Spouse coverage has been elected)*

2. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security# \_\_\_\_\_  
*(To be filled in ONLY if Spouse coverage has been elected)*

**Scheduled Laborers** (Spouse Coverage is not available for this class)

1. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

2. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

3. Name \_\_\_\_\_ Social Security# \_\_\_\_\_

*(If more space is needed, please copy this part of this form)*

**Installment Payment Option:** I elect to have any death benefits under this Plan paid in installments instead of one sum. I understand that this option may be revoked only if I agree to pay an increased premium. I further understand that if I revoke such election it will not apply to any accident that occurred before the date I revoked such election.

**One Sum Option.** I elect to have any death benefits under this Plan paid in one sum.

**Approved By:**

\_\_\_\_\_ Date \_\_\_\_\_  
(Authorized signature)

**UNITED STATES FIRE INSURANCE COMPANY**

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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**SEAT BELT AND AIR BAG BENEFIT RIDER**

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

**Seat Belt Benefit.** We will pay the Maximum Benefit Amount shown below when the Insured Person suffers accidental death and an Accidental Death Benefit is payable under the Policy and the accident causing death occurs while the Insured Person is:

- 1. operating, or riding as a passenger in a Motor Vehicle; and
- 2. wearing a properly fastened, original, factory-installed seat belt.

**Air Bag Benefit.** The Company will also pay the Airbag Maximum Benefit shown in the Schedule if a Seat Belt Benefit is payable under this Rider and if the Insured Person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates upon impact.

Verification of the actual use of the seat belt at the time of the accident and that the Supplemental Restraint System inflated properly upon impact, must be part of an official police report of the accident or be certified, in writing, by the investigating officer(s).

**Motor Vehicle** – as used in this Rider, means a self-propelled motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country, and which is utilized solely for Occupational purposes. Motor Vehicle includes [, but is not limited to, a sedan, station wagon, or sport-utility vehicle. It also includes a motor vehicle of the pickup, panel, van, camper, motor home, or] [a] tractor-trailer vehicle. Motor Vehicle does not include a mobile home or any motor vehicle which is used in mass or public transit.

**Supplemental Restraint System** – as used in this Rider means an air bag which inflates for added protection to the head and chest areas.

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

**Maximum Benefit Payable:    [\$5,000]**

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

# UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## TRAUMA COUNSELING BENEFIT RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

This Rider is attached to and made part of the Policy as of the Policy Effective Date as shown on the Policy Schedule of Benefits. It applies only with respect to accidents that occur on or after that date and prior to the Policy Anniversary/Expiration Date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Rider.

**Trauma Counseling Benefit.** If an Insured Person suffers an Injury, for which an Accidental Dismemberment is payable under the Policy, We will pay Covered Trauma Counseling Expenses that are incurred due to the dismemberment. The Covered Trauma Counseling Expenses must be incurred within one year after the date of the accident causing such loss(es). The benefit will be paid up to the Maximum Benefit Amount per Session and the Maximum Number of Sessions shown below for the Insured Person with respect to all such losses caused by the same accident.

Covered Trauma Counseling Expense(s) as used in this Rider, means an expense that:

1. is charged for a Medically Necessary Trauma Counseling Session for the Insured Person that is provided under the care, supervision or order of a Physician;
2. does not exceed the usual level of charges for similar counseling sessions in the locality where the expense is incurred; and
3. does not include charges that would not have been made if no insurance existed.

**Medically Necessary Trauma Counseling Session (Session)** – as used in this Rider, means any individual, joint, or family mental health counseling session that:

1. is essential to assist the Insured Person in coping with the loss;
2. meets generally accepted standards of medical practice; and
3. is ordered by a Physician for the condition for which it is provided;

**EXCLUSIONS** – In addition to the Exclusions in the Exclusions section of the Policy and in any amendment thereto, Covered Trauma Counseling Expenses do not include any expenses for or resulting from any condition for which the Insured Person is entitled to benefits under the Accidental Medical Expense Benefit.

**Maximum Benefit Per Session:** **[\$100]**

**Maximum Number of Sessions:** **[30]**

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:



Douglas M. Libby  
Chairman and CEO



James Kraus  
Secretary

**UNITED STATES FIRE INSURANCE COMPANY**

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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**PASSENGER COVERAGE RIDER**

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider

**I. Passenger Coverage.**

**A. Schedule of Benefits**

1. Accident Medical/Dental Expense Benefits for a Passenger are payable to the same extent these benefits are payable for You.
2. A Passenger's Principal Sum is [\$10,000].

**B. Eligibility for Benefits:** A Passenger will be covered if the following conditions are met.

1. He or she is Your authorized Passenger.
2. The Accident occurs while he or she is in or on, or boarding or alighting from Your vehicle including travelling to or from Your original dispatch location or the Passenger's home.
3. You are insured under the Policy.

No more than one Passenger may be covered at any one time.

**C. Definition:** "Passenger" means an individual who is riding as Your guest who is not:

1. an employee of the Participant; or
2. an operator or member of Your crew; or
3. receiving any wage or compensation of any kind for this activity; or
4. under 18 years of age; or
5. a hitchhiker.

**II. Benefits**

- A.** Benefits are payable for Accidental Death and Dismemberment and Accident Medical/Dental Expense Benefits as shown in the Schedule of Benefits above.
- B.** The Principal Sum that applies to a Passenger is shown in the Schedule of Benefits above.
- C.** No Disability Income Benefits are payable for a Passenger's Total Disability.
- D.** Unless otherwise agreed to by Us, all benefits for a Passenger's Loss of Life will be paid to the Passenger's estate in monthly installments.

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

**SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:**

Signature

Handwritten signature of Douglas M. Libby in cursive script.

Signature

Handwritten signature of B. Kaus in cursive script.

# NOTICE TO POLICYHOLDERS

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## ARKANSAS NOTICE TO POLICYHOLDERS APPENDIX "A"

### LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

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

#### DISCLAIMER

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

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

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

The Arkansas Life and Health Insurance Guaranty Association  
425 West Capitol Avenue, Suite 3700  
Little Rock, AR 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

# NOTICE TO POLICYHOLDERS

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## COVERAGE

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

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

# NOTICE TO POLICYHOLDERS

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## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1, 000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**UNITED STATES FIRE INSURANCE COMPANY**  
Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

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**AMENDATORY ENDORSEMENT**  
(Applicable to **Arkansas** Residents Only)

This Amendatory Endorsement is attached to and made part of the Master Application, Certificate, Participation Agreement and Policy. It is subject to all of the provisions, limitations and exclusions of the Master Application, Certificate, Participation Agreement and Policy except as specifically modified by this Amendatory Endorsement.

1. The Policy is hereby modified to include following provision:

**Addition of New Persons [Dependents]:** All persons [or dependents] added to the Eligible Classes in the Schedule of Benefits are eligible for insurance under this Policy.

2. The "Assignment" provision under **CLAIMS INFORMATION** in the Certificate is hereby deleted in its entirety and replaced with the following language:

**Assignment**

This coverage may not be assigned. Benefit payments may be assigned at the time of claim. Any payment made by Us in good faith will end Our liability to the extent of the payment. We will deal with the assignee as the owner of the Policy in accordance with the terms of the assignment until We have received, at our home office, written notice of termination of the assignment, or written notice by or on behalf of some other person claiming some interest in the Policy in conflict with the assignment.

3. The "Time of Payment of Claims" provision under **CLAIMS INFORMATION** in the Certificate is hereby deleted in its entirety and replaced with the following language:

**Time of Payment of Claims**

Indemnities payable under the Policy for any loss other than loss for which this Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which We are liable. Any balance remaining unpaid upon the termination of that period of liability will be paid immediately upon receipt of due written proof.

4. The "Fraud Warning" on the Master Application is hereby deleted in its entirety and replaced with the following language:

**Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

5. The "Fraud Warning" on the Participation Agreement is hereby deleted in its entirety and replaced with the following language:

**Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

The President of **United States Fire Insurance Company** witnesses this Rider:

A handwritten signature in black ink that reads "Douglas M. Libby". The signature is written in a cursive style with a horizontal line under the last name.

Douglas M. Libby  
**Chairman and CEO**

SERFF Tracking Number: WESA-126907653 State: Arkansas  
 Filing Company: United States Fire Insurance Company State Tracking Number: 47357  
 Company Tracking Number: AH27700  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: United States Fire Occupational Accident  
 Project Name/Number: United States Fire Occupational Accident/AH27700

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Flesch Certification is attached. <b>Attachment:</b> Occupational Accident Readability Cert Template.pdf	Approved-Closed	11/29/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A as this is a new product filing. <b>Comments:</b>	Approved-Closed	11/29/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statements of Variability <b>Comments:</b> Statements of Variability are attached. <b>Attachments:</b> Fairmont Certificate SOV.FINALCLEAN.pdf Fairmont Policy SOV.docV2.pdf	Approved-Closed	11/29/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Letter of Authorization <b>Comments:</b> Letter of Authorization is attached. <b>Attachment:</b> Signed authorization.pdf	Approved-Closed	11/29/2010

	<b>Item Status:</b>	<b>Status</b>
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SERFF Tracking Number: WESA-126907653 State: Arkansas  
 Filing Company: United States Fire Insurance Company State Tracking Number: 47357  
 Company Tracking Number: AH27700  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: United States Fire Occupational Accident  
 Project Name/Number: United States Fire Occupational Accident/AH27700

**Satisfied - Item:** Trust Agreement Approved-Closed **Date:** 11/29/2010  
**Comments:**  
 Trust Agreement is attached.  
**Attachment:**  
 Group Blanket Trust.pdf

**Item Status:** **Status**  
**Date:**  
**Satisfied - Item:** Consumer Information Notice Approved-Closed 11/29/2010  
**Comments:**  
 Consumer Information Notice is attached.  
**Attachment:**  
 CONSUMER INFORMATION NOTICE AR.pdf

**Item Status:** **Status**  
**Date:**  
**Satisfied - Item:** Cover Letter Approved-Closed 11/29/2010  
**Comments:**  
 Cover Letter is attached.  
**Attachment:**  
 AR Cover Letter.pdf

**UNITED STATES FIRE INSURANCE COMPANY**

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

**READABILITY CERTIFICATION**

To Whom It May Concern:

This is to certify that the attached forms achieved a combined Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Combined Flesch Score
AH27700	Occupational Accident Policy	50.2
AHC27700	Certificate of Insurance	
AH27400-PA	Participation Agreement	
DA-27700	Application	
AH27440-ORQ	Owner/Operator Request for Insurance	
AHE-27700-DR	Dependent Coverage Rider	
AHE-27700-CCR	Coma Benefit Rider	
AHE-27700- EER	Emergency Evacuation Benefit Rider	
AHE-27700-FBR	Felonious Assault Benefit Rider	
AHE-27700-HBR	Hemorrhoid Benefit Rider	
AHE-27700-Hernia	Hernia Benefit Rider	
AHE-27700- Hijacking Benefit Rider	Hijacking Benefit Rider	
AHE-27700-HAVM	Home Alteration and Vehicle Modification Benefit Rider	
AHE-27700-IHI	In-Hospital Indemnity Benefit Rider	
AHE-27700- NDB	Natural Disaster Benefit Rider	
AHE-27700-PE	Passenger Coverage Rider	
AHE-27700-RB	Rehabilitation Benefit Rider	
AHE-27700-SBAB	Seat Belt and Airbag Benefit Rider	
AHE-27700- TCB	Trauma Counseling Benefit Rider	

United States Fire Insurance Company

\_\_\_\_\_  
Signature

Gary M. McGeddy

\_\_\_\_\_  
Printed Name

Executive Vice President

\_\_\_\_\_  
Title

November 17, 2010

\_\_\_\_\_  
Date

**United States Fire Insurance Company**  
**STATEMENT OF VARIABILITY**  
**for**  
**Occupational Accident Certificate of Insurance AHC27700**

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

<b>Policy Page</b>	<b>Provision/Title</b>	<b>Variable #</b>	<b>Variability Range</b>	<b>Description of Variable</b>
<b>FACE PAGE</b>				
1	Arizona Residents	1	Include/Exclude	Include Notice for Arizona residents.
1	Florida Residents	2	Include/Exclude	Include Notice for Florida residents.
1	Texas Residents	3	Include/Exclude	Include Notice for Texas residents.
1	West Virginia Residents	4	Include/Exclude	Include Notice for West Virginia residents.
<b>TABLE OF CONTENTS</b>				
2	Page Numbers	1	Include/Exclude	Page Numbers may change.
<b>SCHEDULE OF BENEFITS</b>				
3	Policyholder	1	Include/Exclude	John Doe information.
3	Policy Number	2	Include/Exclude	John Doe information.
3	Participant	3	Include/Exclude	John Doe information.
3	Participant's Effective Date	4	Include/Exclude	John Doe information.
3	Participant's Anniversary Date	5	Include/Exclude	John Doe information.
3	Insured	6	Include/Exclude	John Doe information.
3	Social Security Number	7	Include/Exclude	John Doe information.
3	Insured's Effective Date	8	Include/Exclude	John Doe information.
3	Class 1 Owner/Operator through Class 4 Scheduled Laborer (Entire Section)	9	Include/Exclude Each Class	Each class within this section may be added or removed depending on which classes the Policyholder chooses.
3	If You are in an Eligible Class other than Owner/Operator (Entire Section)	10	Include/Exclude	Allows Policyholder to include if Insured is in eligible class 2, 3 or 4.
3	Who Pays	11	Include/Exclude	Defines who pays for coverage.
3	Premium Due Date	12	Include/Exclude	Sets due date for premium.
3	Age Limit	13	Include/Exclude	Defines age limit.
4	Occupational Disease	14	Include/Exclude	Allows Policyholder to select coverage.
4	Cumulative Trauma	15	Include/Exclude	Allows Policyholder to select coverage.
4	Hernia	16	Include/Exclude	Allows Policyholder to select coverage.
4	Non-Occupational Accident	17	Include/Exclude	Allows Policyholder to select coverage.
4	Dependent Coverage	18	Include/Exclude	Allows Policyholder to select coverage.
4	Installment Payment Option (Entire Section)	19	Include/Exclude	Allows Policyholder to select installment payment option for death benefits.
<b>AMOUNTS OF INSURANCE</b>				
4	Class 1 – Accidental Death and Dismemberment Principal Sum	1	Include/Exclude	Allows variability by class; defines Principal Sum of \$50,000.
4	Class 2 – Accidental Death and Dismemberment Principal Sum	2	Include/Exclude	Allows variability by class; defines Principal Sum of \$50,000.
4	Class 3 - Accidental Death and Dismemberment	3	Include/Exclude	Allows variability by class; defines Principal Sum of \$25,000.

	Principal Sum			
4	Class 4 - Accidental Death and Dismemberment Principal Sum	4	Include/Exclude	Allows variability by class; defines Principal Sum of \$10,000.
4	Class 1 – Temporary Total Disability Weekly Benefit	5	Include/Exclude	Allows variability by class; defines calculation of benefit; allows Policyholder to reduce benefit by Other Income Benefits.
4	Class 2 – Temporary Total Disability Weekly Benefit	6	Include/Exclude	Allows variability by class; defines calculation of benefit; allows Policyholder to reduce benefit by Other Income Benefits.
4	Class 3 – Temporary Total Disability Weekly Benefit	7	Include/Exclude	Allows variability by class; defines calculation of benefit; allows Policyholder to reduce benefit by Other Income Benefits.
4	Class 4 – Temporary Total Disability Weekly Benefit	8	Include/Exclude	Allows variability by class; defines calculation of benefit; allows Policyholder to reduce benefit by Other Income Benefits.
4	Class 1 – Permanent Total Disability Monthly Benefit	9	Include/Exclude	Allows variability by class; defines calculation of benefit.
4	Class 2 – Permanent Total Disability Monthly Benefit	10	Include/Exclude	Allows variability by class; defines calculation of benefit.
4	Class 3 – Permanent Total Disability Monthly Benefit	11	Include/Exclude	Allows variability by class; defines calculation of benefit.
4	Class 4 – Permanent Total Disability Monthly Benefit	12	Include/Exclude	Allows variability by class; defines calculation of benefit.
4	Class 1 - Accident Medical/Dental Expense Benefit – Maximum Benefit	13	Include/Exclude	Allows variability by class; defines Maximum Benefit of \$100,000 per accident.
4	Class 2 - Accident Medical/Dental Expense Benefit – Maximum Benefit	14	Include/Exclude	Allows variability by class; defines Maximum Benefit of \$100,000 per accident.
4	Class 3 - Accident Medical/Dental Expense Benefit – Maximum Benefit	15	Include/Exclude	Allows variability by class; defines Maximum Benefit of \$100,000 per accident.
4	Class 4 - Accident Medical/Dental Expense Benefit – Maximum Benefit	16	Include/Exclude	Allows variability by class; defines Maximum Benefit of \$100,000 per accident.
4	Temporary Total Disability Weekly Benefit (a)	17	Include/Exclude	Varies by Average Weekly Earnings (70% of Average Weekly Earnings), subject to a maximum of \$500 per week); also allows reduction by other income benefits.
4	Permanent Total Disability Monthly Benefit (b)	18	Include/Exclude	Variable by Average Weekly Earnings (4.3 times Average Weekly Earnings multiplied by 0.70), subject to a maximum amount of \$1,505 per month minus Other Income Benefits.
<b>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS</b>				
4	Time Limit for Loss	1	Include/Exclude	Defines period as 180 or 365 days from date of the Occupational Accident.
<b>TOTAL DISABILITY BENEFITS</b>				
4	Daily Benefit - Temporary Total Disability	1	Include/Exclude	Defines benefit as 1/7 <sup>th</sup> of the Weekly Benefit.
4	Daily Benefit – Permanent Total Disability	2	Include/Exclude	Defines benefit as 1/30 <sup>th</sup> of the Monthly Benefit.

4	Benefit Waiting Period - Temporary Total Disability	4	Include/Exclude	Defines period as 7 days of continuous Total Disability.
4	Benefit Waiting Period - Permanent Total Disability	5	Include/Exclude	Defines period as 180 days of continuous Total Disability.
4	Maximum Payment Period (Entire Section)	6	Include/Exclude	Defines period for Temporary Total Disability as 26 weeks and period for Permanent Total Disability at 60 months.
4	Reduction in Disability Income Benefits	7	Include/Exclude	Allows Policyholder to reduce benefits; allows reduction by Other Income Benefits/Social Security benefits.
5	Dismemberment Schedule of Benefits	8	Include/Exclude	Include if benefit is applicable for group.
<b>ACCIDENT MEDICAL/DENTAL EXPENSE BENEFITS</b>				
5	Time Limit for Loss	1	Include/Exclude	Defines period as 30, 60, or 90 days from the date of injury in covered Occupational Accident.
5	Maximum Payment Period	2	Include/Exclude	Defines period as 6 or 12 months or 52 or 104 weeks from the date of the covered injury.
5	Deductible (Entire Section)	3	Include/Exclude	Allows Policyholder to select; defines deductible as \$50 per Covered Person per Occupational Accident.
5	Coinsurance Rate	4	Include/Exclude	Defines rate as 100% of Reasonable Charges.
5	Combined Single Benefit Limit (Entire Section)	5	Include/Exclude	Allows Policyholder to select; defines limit as \$1,000,000 under all benefits for any one person due to one Occupational Accident.
5	Additional Benefits (Entire Section)	6	Include/Exclude	Allows Policyholder to select additional benefits relevant to the participant.
<b>ADDITIONAL DEATH AND DISMEMBERMENT BENEFIT</b>				
6	Accidental Death and Dismemberment Benefit (Entire Section)	1	Include/Exclude	Allows Policyholder to add accidental death and dismemberment benefits.
6	Subject to Combined Single Benefit Limit	2	Include/Exclude	Allows benefit to be subject to Combined Single Benefit Limit
6	Dismemberment Schedule of Benefits	3	Include/Exclude	Include if benefit is applicable.
<b>DISABILITY INCOME BENEFIT</b>				
7	Disability Income Benefit (Entire Section)	1	Include/Exclude	Allows Policyholder to add disability income benefits.
7	Subject to Combined Single Benefit Limit	2	Include/Exclude	Allows benefit to be subject to Combined Single Benefit Limit
7	Partial Disability Benefit (Entire Section)	3	Include/Exclude	Allows Policyholder to add partial disability benefit.
<b>ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT</b>				
8	Accident Medical/Dental Expense Benefit (Entire Section)	1	Include/Exclude	Allows Policyholder to add accident medical/dental expense benefits.
8	Subject to Combined Single Limit	2	Include/Exclude	Allows benefit to be subject to Combined Single Benefit Limit.

8	Subject to Schedule of Benefits	3	Include/Exclude	Allows benefit to be subject to Deductible, Coinsurance Rate, Maximum Payment Periods, and Maximum Benefits in Schedule of Benefits
8	When Covered Expenses are paid	4	Include/Exclude	Allows Covered Expenses to be paid only when they are in excess of amounts paid by any other Health Care Plan, except for the first \$100 of claims.
8	Payment of benefits	5	Include/Exclude	Allows benefits to be paid without regard to any coordination of benefit provisions in any other Health Care Plan.
9	Ambulance Services (Entire Section)	6	Include/Exclude	Allows Policyholder to add ambulance services.
9	Ambulatory Surgical Center Charges (Entire Section)	7	Include/Exclude	Allows Policyholder to add ambulatory surgical center charges.
9	Anesthetics (Entire Section)	8	Include/Exclude	Allows Policyholder to add anesthetics.
9	Dental Services (Entire Section)	9	Include/Exclude	Allows Policyholder to add dental services.
9	Health Care Provider's Services (Entire Section)	10	Include/Exclude	Allows Policyholder to add health care provider's services.
9	Hospital Charges (Entire Section)	11	Include/Exclude	Allows Policyholder to add hospital charges.
9	Laboratory Tests and X-rays (Entire Section)	12	Include/Exclude	Allows Policyholder to add laboratory tests and x-rays.
9	Medical Supplies (Entire Section)	13	Include/Exclude	Allows Policyholder to add medical supplies.
10	Nursing Services (Entire Section)	14	Include/Exclude	Allows Policyholder to add nursing services.
10	Occupational Therapy (Entire Section)	15	Include/Exclude	Allows Policyholder to add occupational therapy.
10	Physician's Services (Entire Section)	16	Include/Exclude	Allows Policyholder to add physician's services; allows limit on such covered expenses for multiple surgical procedures – for second procedure, to 50% of the covered expenses, for subsequent procedures, to 25% of the covered expenses.
10	Physiotherapy (Entire Section)	17	Include/Exclude	Allows Policyholder to add physiotherapy.
10	Skilled Home Health Care (Entire Section)	18	Include/Exclude	Allows Policyholder to add skilled home health care; allows payment for expenses to be limited to first 80 visits for each Occupational Accident.
10	Skilled Nursing Facility Charges (Entire Section)	19	Include/Exclude	Allows Policyholder to add skilled nursing facility charges; allows payment for such expenses to be limited to first 120 days of confinement for each Occupational Accident.
11	Speech Therapy (Entire Section)	20	Include/Exclude	Allows Policyholder to add speech therapy.
11	Expenses Not Covered (Entire Section)	1	Include/Exclude	Allows Policyholder to select expenses not covered.
<b>CLAIMS INFORMATION</b>				
13	Address for Notice of Claim	1	Include/Exclude	Allows Policyholder to select to whom/address notice of claim must be sent.

<b>GENERAL PROVISIONS REGARDING AN INDIVIDUAL'S COVERAGE</b>				
15	Eligibility Waiting Period	1	Include/Exclude	Allows Policyholder to include waiting period.
15	How to File a Request	2	Include/Exclude	Allows Policyholder to include effective date of coverage for insureds who are not working because they are disabled on the date coverage would start.
16	Accident Medical/Dental Expense Benefits (Entire Section)	3	Include/Exclude	Allows Policyholder to extend accident medical/dental expense benefits; defines length of period for which such benefits may be extended as up to 90 days; limits benefits payable to benefit maximum for this benefit in Schedule of Benefits.
<b>DEFINITIONS</b>				
16	Appropriate Care (Entire Section)	1	Include/Exclude	Include if "Appropriate Care" appears in any benefit or exclusion.
16	Average Weekly Earnings (Entire Section)	2	Include/Exclude	Include if Disability Income Benefit is included; allows Policyholder to select definition of average weekly earnings.
16	Benefit Waiting Period (Entire Section)	3	Include/Exclude	Include if Disability Income Benefit is included.
16	Co-Driver (Entire Section)	4	Include/Exclude	Include if policy contains benefits for co-drivers.
16	Contract Driver (Entire Section)	5	Include/Exclude	Include if policy contains benefits for contract drivers.
17	Covered Contract (Entire Section)	6	Include/Exclude	Include if policy includes benefits for owners/operators.
17	Covered Person (Entire Section)	7	Include/Exclude	Include if there is a request for insurance.
17	Cumulative Trauma (Entire Section)	8	Include/Exclude	Include if Cumulative Trauma benefit is included.
17	Health Care Plan (Entire Section)	9	Include/Exclude	Include if accident medical expense benefits are included.
17	Home Health Care Agency (Entire Section)	10	Include/Exclude	Include if accident medical expense benefits are included.
18	Immediate Family (Entire Section)	11	Include/Exclude	Include if accident medical/dental expense benefits are included.
18	Injury (Entire Section)	12	Include/Exclude	
18	Laborer (Entire Section)	13	Include/Exclude	Include if policy contains benefits for laborers.
18	Medical Emergency (Entire Section)	14	Include/Exclude	Include if accident medical./dental expense benefits are included.
18	Medically Necessary (Entire Section)	15	Include/Exclude	Include if accident medical/dental expense benefits are included.
18	Occupational Accident (Entire Section)	16	Include/Exclude	Defines occupational accident; defines time within which bodily injury must result from such accident as 72 hours of the date of the accident.
19	Occupational Disease (Entire Section)	17	Include/Exclude	Include if occupational disease coverage is selected; include if "occupational disease" appears in any benefit or exclusion.
19	Other Income Benefits (Entire Section)	18	Include/Exclude	Include if Disability Income Benefit is included.
19	Other Services and Supplies (Entire Section)	19	Include/Exclude	Allows Policyholder to include if accident medical/dental expense benefit is included.

19	Owner/Operator (Entire Section)	20	Include/Exclude	Include if policy contains benefits for owners/operators.
19	Participant (Entire Section)	21	Include/Exclude	Allows Policyholder to include definition of Participant.
19	Physician (Entire Section)	22	Include/Exclude	Include if physician is used in selected benefits of the policy.
20	Policy (Entire Section)	23	Include/Exclude	Allows Policyholder to include definition of Policy.
20	Policyholder (Entire Section)	24	Include/Exclude	Allows Policyholder to include definition of Policyholder.
20	Reasonable Charge (Entire Section)	25	Include/Exclude	Include if accident medical/dental expense benefit is included.
20	Room and Board (Entire Section)	26	Include/Exclude	Include if accident medical/dental expense benefit/skilled nursing facility charges are included.
20	Schedule of Benefits (Entire Section)	27	Include/Exclude	Allows Policyholder to include definition of Schedule of Benefits.
20	Total Disability (Entire Section)	28	Include/Exclude	Include if Disability Income Benefit is selected or other benefits include "disability"; allows Policyholder to select number of weeks – 26, 52, 104, 156, or 208 – for inability to perform all substantial and material duties of regular employment or occupation; allows Policyholder to limit earnings to less than 80% of pre-disability earnings; allows Policyholder to select number of weeks – 26, 52, 104, 156, or 208 – for period of Total Disability continuing more than.
21	Under Contract (Entire Section)	29	Include/Exclude	Allows Policyholder to include definition of Under Contract.

**United States Fire Insurance Company**  
**STATEMENT OF VARIABILITY**  
for  
**Occupational Accident Group Accident Policy AH27700**  
**Felonious Assault Benefit Rider AHE-27700-FBR**  
**Coma Benefit Rider AHE-27700-CCR**  
**Emergency Evacuation Benefit Rider AHE-27700-EER**  
**Hemorrhoid Benefit Rider AHE-27700-HBR**  
**Hernia Benefit Rider AHE-27700-Hernia Rider**  
**Hijacking Benefit Rider AHE-27700-Hijacking Benefit Rider**  
**Home Alteration and Vehicle Modification Benefit Rider – AHE-27700-HA/VM**  
**In-Hospital Indemnity Benefit Rider – AHE27700-HI**  
**Natural Disaster Benefit Rider – AHE-27700-NDB**  
**Passenger Coverage Rider - AHE-27700-PE**  
**Rehabilitation Benefit Rider – AHE-27700-RB**  
**Seat Belt and Air Bag Benefit Rider – AHE-27700-SBAB**  
**Trauma Counseling Benefit Rider – AHE-27700-TCB**

Language that is bracketed in the form is intended to be variable. Below is an explanation of those variables.

<b>Policy/Rider Page</b>	<b>Provision/Title</b>	<b>Variable #</b>	<b>Variability Range</b>	<b>Description of Variable</b>
<b>POLICY - FACE PAGE</b>				
1	Policy Holder	1	Include/Exclude	John Doe information
1	Policy Number	2	Include/Exclude	John Doe information.
1	Policy Effective Date	3	Include/Exclude	John Doe information.
1	Policy Anniversary Date	4	Include/Exclude	John Doe information.
1	State of Delivery	5	Include/Exclude	John Do information.
<b>POLICY - GENERAL POLICY PROVISIONS</b>				
2	Page Numbers	1	Unique Numbers	Page Numbers may change.
2	Termination of the Policy	2	Include/Exclude	Defines number of days as 10 after Company sends notice of termination as possible effective date of termination.
2	Renewal	3	Text	Defines number of days as at least 31 for Company to provide advanced written notice or authorized electronic or telephonic notice of intent to nonrenew.
	Cancellation of Participation	4	Include/Exclude	Defines effective date of cancellation of participation in the policy by the Company as not less than 31 days after Company mails written notice to Participant.
3	Premium Rates – notice re change	5	Include/Exclude	Defines number of days as at least 31 for sending advanced written or authorized electronic or telephonic notice of rate change.
3	Pennsylvania and Louisiana Participants	6	Include/Exclude	Include if policy covers Pennsylvania or Louisiana residents.
3	Rate increase	7	Include/Exclude	Outlines guaranteed rate term.
3	Experience Rating	8	Include/Exclude	Allows Policyholder to experience rate.
<b>RIDERS</b>				
1	Felonious Assault Benefit	1	Include/Exclude	Accidental Death Benefit, Accidental

	Rider			Dismemberment Benefit, Temporary Total Disability Benefit or Continuous Disability Benefit must be included; defines felonious assault maximum benefit as \$10,000.
1	Coma Benefit Rider	1	Include/Exclude	Allows Policyholder to define incurral period as 4 to 156 weeks; defines principal sum as \$10,000.
1	Emergency Evacuation Benefit Rider	1/2	Include/Exclude	Telephone number of authorized claim representative may change; defines maximum benefit as \$10,000.
1	Hemorrhoid Benefit Rider	1	Include/Exclude	Accident Medical Expense Benefit and Temporary Total Disability Benefit must be included; defines lifetime maximum benefit amount for all benefits as \$5,000.
1	Hernia Benefit Rider	1	Include/Exclude	Accident Medical Expense Benefit and Temporary Total Disability Benefit must be included; defines maximum hernia injury benefit as \$5,000 and lifetime maximum hernia injury benefit as \$10,000.
1	Hijacking Benefit Rider	1	Include/Exclude	Accidental Death Benefit or Accidental Dismemberment Benefit must be included; defines hijacking maximum benefit amount as \$5,000 and lifetime maximum hijacking benefit amount as \$10,000.
1	Home Alteration and Vehicle Modification Benefit Rider	1/2	Include/Exclude	Accidental Dismemberment Benefit must be included; defines maximum benefit for alteration and vehicle modification as \$5,000.
1	In-Hospital Indemnity Benefit Rider	1	Include/Exclude	Allows Policyholder to select incurral period of 4 to 156 weeks, waiting period of 7 to 14 days; defines daily maximum benefit as \$100, maximum number days per injury as 10, and lifetime maximum benefit as 5,000.
1	Natural Disaster Benefit Rider	1	Include/Exclude	Accidental Death Benefit and Accidental Dismemberment Benefit must be included; defines maximum benefit amount as \$5,000.
1	Passenger Coverage Rider	1	Text	The benefit options for the AD&D benefit are \$10,000, \$25,000, \$50,000 and \$100,000.
1	Rehabilitation Benefit Rider	1/2	Include/Exclude	Accidental Dismemberment Benefit must be included; defines maximum benefit per injury as \$5,000 and lifetime maximum benefit as \$10,000.
1	Seat Belt and Air Bag Benefit Rider	1	Include/Exclude	Accidental Death Benefit must be included; allows Policyholder to select example of motor vehicle as including sedan, station wagon, or sport utility vehicle... a motor vehicle of the pickup, panel, van, camper, motor home or a; defines maximum benefit amount as \$5,000.
1	Trauma Counseling Benefit Rider	1	Include/Exclude	Accidental Dismemberment Benefit must be included; defines maximum benefit per session as \$100 and maximum number of sessions as 30.



October 1, 2010

United States Fire Insurance Company  
FEIN#: 13-5459190  
NAIC#: 0158-21113

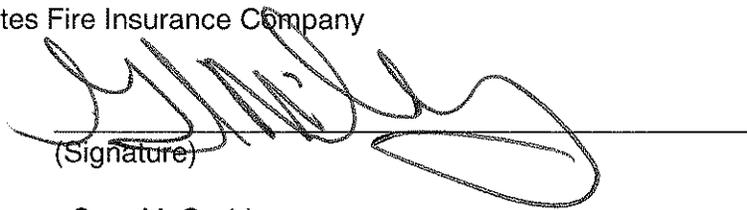
Letter of Authorization  
Filing of Forms, Rates and Rules

Dear Sir or Madame:

In accordance with the applicable statutes and regulations in your state, Darcy Lebau and Westmont Associates are hereby authorized to file form, rate and rate filings and respond to Department of Insurance inquiries to such filings on behalf of United States Fire Insurance Company.

For: United States Fire Insurance Company

By:

A handwritten signature in black ink, appearing to read "Gary McGeddy", written over a horizontal line. Below the signature, the word "(Signature)" is printed in a smaller font.

Printed Name: Gary McGeddy

Title: Executive Vice President

## AGREEMENT AND DECLARATION OF TRUST

THIS AGREEMENT AND DECLARATION OF TRUST is entered into in the state of Illinois as of this 30 day of May, 2001, effective from May 30th, 2001, by the Marine Bank, Springfield, an Illinois banking institution, hereafter referred to as the "Trustee", TIG Insurance Company, a California corporation, hereinafter referred to as "Administrator", and the various organizations who become parties hereto, hereinafter referred to as the "Participating Organizations." All of the above are individually and collectively referred to herein as the "parties."

### WITNESSETH

WHEREAS, it has been proposed that the Trustee provide blanket or group insurance to persons affiliated with Participating Organizations and members of families of such persons as defined in Article II hereof and that blanket or group insurance be obtained for the benefit of such persons; and

WHEREAS, to give effect to this proposal, the Participating Organizations desire to create a trust and to establish a trust fund to be used in the manner hereinafter set forth; and

WHEREAS, the Trustee has undertaken and agreed to act as Trustee of a trust fund to be established in connection with the plans of insurance which are to provided hereunder.

NOW, THEREFORE, in consideration of the Insurance it is mutually agreed as follows:

### ARTICLE I

#### Purpose of the Trust

**Section 1.01.** This trust shall be known as the "Group and Blanket Accident & Health Insurance Trust", also hereinafter referred to as the "Trust."

**Section 1.02.** The purpose of the Trust is to provide through blanket or group policies issued by insurance carriers, insurance for persons affiliated with Participating Organizations and members of families of such persons.

## ARTICLE II

### Participating Organizations

**Section 2.01.** Organizations eligible to participate in the Trust are those which are meet the eligibility requirements of any insurance policy procured by the Trustee.

**Section 2.02.** Each eligible organization desiring to participate in this Trust will fully execute a Participation Agreement in substantially the form incorporated herein as "Exhibit A" and submit it to the Administrator along with an initial payment determined by the Administrator on the basis of the insurance requested. This Participation Agreement must be accepted by the Administrator before an organization may participate. An organization whose Participation Agreement is not accepted will receive a refund of any payment submitted with the Participation Agreement. An eligible organization which is accepted for participation shall thereafter make payments for insurance and administration of this Trust, on such dates and in such amounts as the Administrator may require. The participation of a Participating Organization in this Trust is contingent on, and will continue only so long as those insured through the organization are validly insured pursuant to the provision of one or more insurance policies issued to the Trustee.

**Section 2.03.** If the Trustee has been issued more than one blanket or group insurance policy, the Administrator will be authorized to specify under which policy a Participating Organization's members/employees will be initially or ultimately insured.

**Section 2.04.** The payments by Participating Organizations referred to in Section 2.02 of this Article II will be designated as "organization payments." To the extent and in the manner permitted by any policy, rules, regulations, and laws which are applicable, each Participating Organization may require from its employees or the families of such persons, contribution toward or payment of the cost of providing blanket or group insurance under a policy and these contributions shall be included in or the payments shall comprise the organization payments.

**Section 2.05.** To properly administer the Trust and the insurance procured by the Trustee, the Trustee or Administrator may adopt such rules and regulations as are deemed necessary or advisable and all Participating Organizations shall comply with these rules and regulations. The Trustee or the Administrator will have the right to require such information from the Participating Organizations as they deem useful or necessary to discharge their duties under this Trust Agreement. The Trustee will not be required to determine the accuracy or sufficiency of any information or computations received from the Participating Organizations.

**Section 2.06.** No Participating Organization, insured person, or person claiming by or through any insured person, will have any claim against any funds or property of the Trust. The rights and interests of insured persons and persons claiming by or through them will be limited to the insurance benefits specified in the policies; however, this

section will not prevent these parties from sharing in refunds, if any, should the Trust be terminated. All termination refunds will be made directly to the organizations participating in the Trust at the time the refund is declared and the interest of any individual insured will be paid to his or her Participating Organization. Neither the Trustee nor the Administrator will be responsible for the further distribution of the refunds from the Participating Organization to the individual insured or any person claiming by or through any insured person.

### ARTICLE III

#### Compensation of the Trustee and Insurance Company

**Section 3.01.** The Trustee will be entitled to receive from the Administrator a reasonable compensation for its services, as may from time to time be agreed upon by the Trustee and the Administrator.

**Section 3.02.** The Administrator will be entitled to receive an administrative charge from the organization payments of each Participating Organization. The Administrator will see that all Participating Organizations are notified of the amount of the administrative charge and will not increase the administrative charge without 30 days advance written notice of the increase.

### ARTICLE IV

#### Powers and Duties of the Trustee

**Section 4.01.** The Trustee shall be authorized, but not required, to procure and hold blanket or group insurance policies in furtherance of the purposes of this Trust Agreement. The term "policy", as used herein, will include any rider, endorsement or amendment made part of a policy. The Trustee has no responsibility or liability for the content of the policies.

**Section 4.02.** In procuring an insurance policy, the Trustee, upon the written direction of the Administrator, will agree with the insurers on matters such as waiting periods, conditions of eligibility, and other conditions.

**Section 4.03.** The Trustee, upon the written request and approval of the Administrator, may agree with an insurer to any alteration, modification, or amendment of its policies, and may take any action respecting the insurance provided under these policies, which may be necessary or advisable to accomplish the purposes of this Trust Agreement.

**Section 4.04.** The Trustee may be authorized, but not required, to collect either insurance premiums or proceeds. Should it receive any money for any reason (other than to reimburse it for costs, expenses or taxes for which it is entitled to be reimbursed

hereunder, or as payment of its fees) it shall promptly deliver the money to the Administrator. It shall also deliver to the Administrator all correspondence that it may receive in connection with this Trust.

**Section 4.05.** The Trustee shall promptly notify the Administrator in writing of any tax or assessment asserted against or levied upon the Trustee or the Fund because of the existence of the Trust.

**Section 4.06.** The Trustee will not be obligated to commence or maintain any litigation with respect to the Trust unless it is satisfactorily indemnified against all expenses and liabilities that may be incurred thereby, including reasonable attorney's fees.

**Section 4.07.** The Trustee will not be liable for any act performed or not performed pursuant to a signed written directive of the Administrator. The Administrator shall indemnify the Trustee for any loss which the Trustee may sustain by reason of any act performed or omitted in reliance on a signed written directive of the Administrator.

**Section 4.08.** The Trustee shall act in good faith and with ordinary care and so long as it does so, it shall incur no responsibility, liability or obligation for loss or damage to any person as a result of any act taken or omitted by it or any of its agents or employees.

**Section 4.09.** The Trustee may only amend or modify this Trust with the written consent of the Administrator.

**Section 4.10.** The Trustee shall not, nor will it be required to furnish copies of this Trust to any institution, company, persons insured under this Trust or any other parties, unless expressly directed to do so by the Administrator.

**Section 4.11.** In no event will the Trustee be deemed to be guarantor of solvency of any insurer from which a policy is purchased through this Trust. Nor will the Trustee be deemed to be in any respect an insurer or insurance company. The Trustee will not be liable for the failure, refusal or inability of any insurance company which issues a policy under this Trust to make payments required under a policy. The provisions and coverages provided under any policy issued through this Trust shall be limited to those provided by the provisions of the policy; the provisions of the policy shall apply notwithstanding anything else contained herein or elsewhere.

## ARTICLE V

### Resignation, Removal and Substitution of the Trustees

**Section 5.01.** The Trustee shall have the right to resign at any time by delivering to the Administrator a written notice to take effect not less than sixty days after delivery thereof, unless the Administrator shall accept a shorter notice as adequate.

**Section 5.02.** The Administrator shall have the right to remove the Trustee at any time by delivering to the Trustee a written notice to take effect not less than sixty days after delivery thereof (unless the Administrator shall accept a shorter notice as adequate), provided a successor Trustee has accepted in writing.

**Section 5.03.** The Trustee, upon resigning or being removed, shall assign, transfer, convey and deliver to the successor Trustee, all of its interest in the hereinbefore described policies and any related records, and thereupon shall be fully released and discharged from all further obligations and liabilities hereunder, and the successor Trustee will succeed to obligations, and immunities conferred upon the original Trustee.

**Section 5.04.** The Trustee resigning or being removed will have the right to settlement of its accounts, and upon failure of the Administrator to agree thereon, may apply to a court of competent jurisdiction for adjudication.

**Section 5.05.** Any successor to the Trustee, whether through sale or transfer of its business, conversion, consolidation, merger, or otherwise, will forthwith become the successor Trustee and succeed to all rights, title, interest, powers, discretions, obligations, and immunities of the Trustee hereunder, with the same effect as though the successor were originally named herein as the Trustee.

## ARTICLE VI

### Dealings With the Trustee

No one dealing with the Trustee will be obligated to see that the terms of the Trust have been complied with or inquire into the necessity or expediency of any acts of the Trustee. Every instrument effected by the Trustee may be relied upon as to any facts set forth therein and shall be conclusive that:

- A. At the time of delivery of said instrument the Trust was in full force and effect and except where there has been notice of an amendment, was in the form set forth in this Agreement as of its effective date;
- B. Said instrument was executed in accordance with the terms and conditions of the Trust; and

- C. The Trustee was duly authorized and empowered to execute such agreement.

## ARTICLE VII

### Nature of the Fund

The term "Fund", as used herein, will mean the insurance policies issued to the Trustee, as well as all dividends or experience refunds or other sums payable on account of these policies and any other property received and held by the Administrator for uses and purposes as set forth in this Trust.

## ARTICLE VIII

### Powers and Duties of the Administrator

**Section 8.01.** The Administrator will serve as the named fiduciary of the Fund, and as such, will control and manage the operation and administration of the Trust.

**Section 8.02.** The Administrator will be authorized, but not required, to open such bank accounts as its deems necessary and to disburse funds therefrom in the name of the Trust, in furtherance of the purposes of this Trust Agreement.

**Section 8.03.** The Administrator will determine the eligibility of organizations, and accept or reject each Participation Agreement on the basis of that determination. The Administrator will periodically provide participation data to the Trustee.

**Section 8.04.** The Administrator will have the right and power to assess the Participating Organizations in any amounts as may be appropriate to fulfill the purposes of this Trust. Such assessments will be in an amount sufficient to pay the premiums on the insurance coverage for each Participating Organization and its affiliated members (employees and family members of such insured persons), plus an administrative charge, (see Article III, Section 3.02), which will be determined by the Administrator. It will be an obligation of the Administrator to see that all Participating Organizations are notified of all assessments.

**Section 8.05.** If any assessment is not paid in full by the Participating Organization within thirty (30) days after the payment was due, the Administrator may, without notice, terminate the Participating Organization's rights under this Trust and discontinue such insurance as may be carried for the benefit of the Participating Organization and its affiliated members, other persons and family members of such insured persons. The Participating Organization will still be liable for unpaid assessments. Nothing in this section will have any effect on any applicable "grace period" provision of any insurance policy.

**Section 8.06.** At the discretion of the Administrator, any experience refunds may be distributed among the Participating Organizations in one or more of the following ways:

- A. To purchase increased benefits;
- B. To reduce the cost of insurance; or
- C. To be held in a reserve fund to meet future contingencies.

**Section 8.07.** The Administrator shall have the right to inspect the records of Participating Organizations so far as they are pertinent to the purpose of this Agreement and may require reports from Participating Organizations as may be necessary for the administration of the Trust and the insurance policies issued to the Trust.

**Section 8.08.** The Administrator may assign any of its powers and rights hereunder and delegate any of its duties and responsibilities hereunder to any company who has issued an insurance policy to the Trust.

**Section 8.09.** The Administrator shall keep true and accurate books and accounts and records of all its transactions.

**Section 8.10.** The Administrator shall not be personally liable for any action taken or omitted in good faith pursuant to this Trust Agreement, nor for any action taken or omitted by an agent, employee or attorney selected with reasonable care.

**Section 8.11.** Any successor to the Administrator whether through sale or transfer of its business, conversion, consolidation, merger or otherwise, will succeed to all rights, title, interests, power, discretions, obligations, and immunities of the Administrator hereunder, with the same effect as though the successor were originally named herein as the Administrator.

## ARTICLE IX

### Amendment and Termination of the Trust

**Section 9.01.** The provisions of this Trust Agreement may be amended at any time by an instrument executed by the Trustee and Administrator.

**Section 9.02.** Unless earlier terminated, this Trust shall terminate 21 years after the effective date of this Agreement.

**Section 9.03.** In addition to any other termination provision which may be contained herein, in the event that all of the Participating Organizations decide to discontinue their insurance under the Trust, the Administrator will apply any remaining

funds and other property of the Trust to the purposes stated herein. Upon the disbursement of all remaining funds or property, this Trust will terminate.

## ARTICLE X

### Notices

All notices, documents and correspondence regarding this Trust shall be in writing and shall be deemed to have been delivered when sent postage prepaid by United States registered or certified mail return receipt requested to the address described below or such other address as may be designated by notice given from time to time in accordance with this Section by the party desiring to change its address:

To the Trustee: Marine Bank, Springfield  
c/o Mr. Tom McNichols, Vice President and Trust Officer  
3050 West Wabash Avenue  
Springfield, IL 62704

To the Administrator: TIG INSURANCE COMPANY  
5205 N. O'Conner Blvd  
Irving, Texas 75039

Attention: General Counsel

To the Participating Organizations:

The address shown on the Participation Agreement

## ARTICLE XI

### Miscellaneous Provisions

**Section 11.01.** The Administrator or the Trustee may employ legal assistance when deemed necessary in the furtherance of this Trust.

**Section 11.02.** The Trustee and Administrator will each have the right to require any information from the other as they may deem to be useful or necessary in the discharge of their duties under this Agreement. The Trustee will not be required to determine the accuracy or sufficiency of any information or computation received from the Administrator or any insurer.

**Section 11.03.** Any Participating Organizations signing this Agreement or any amendments hereto shall have no liability to any other Participating Organizations or

other party by reason of the creation, amendment, or operation of this Trust.

**Section 11.04.** The sequence or locations of the various Articles and Sections in this Agreement will not be used to determine any specific meaning.

**Section 11.05.** This Agreement shall extend to and be binding upon the successors and assigns of the parties.

**Section 11.06.** Except as modified by this Agreement, the parties will be governed by and have all authority, rights, powers and privileges set forth in the laws of the District of Columbia as the same may be amended from time to time, and any relevant federal legislation.

## ARTICLE XII

### Situs and Construction of Trust

This Trust is created and accepted in the state of Illinois and all questions pertaining to its validity, construction and administration shall be determined in accordance with the laws of the Illinois.

In the event that any portion of this Agreement shall be construed by a court of competent jurisdiction to be illegal or unenforceable, said decree, order or judgment shall affect only such provisions as are referred to and all of the other provisions in said Agreement shall be enforceable as to each of the parties hereto.

**AGREEMENT AND INDEMNIFICATION**

This Agreement made and entered into this 30 th day of May, 2001 in Springfield, Illinois by and between TIG Insurance Company (hereinafter called "Insurance Company") and Marine Bank, Springfield, Trustee of the Group and Blanket Accident and Health Insurance Trust" (hereinafter called "Trustee").

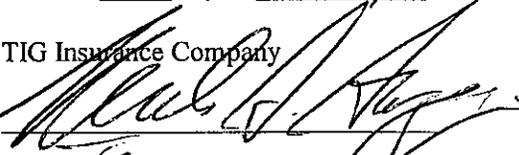
**WITNESS THAT:**

The Trustee did by Agreement and Declaration of Trust effective May 30<sup>th</sup>, 2001 agree to act as Trustee of a trust fund to be established in connection with the plans of insurance to be provided and which was and is to be known as the Group and Blanket Accident and Health Insurance Trust.

Now, therefore, in consideration of the Trustee's agreement to be named as Trustee and the benefits accruing to the Insurance Company by reasons of said Agreement, Insurance Company does hereby agree to indemnify and save the Trustee harmless against all liability, loss or expense (including but not limited to costs and attorney's fees) as a result of the administration or failure to administer the said Agreement and Declaration of Trust.

Dated as of this 30<sup>th</sup> day of MAY, 2001

TIG Insurance Company

By: 

Title: Treasurer

Marine Bank, Springfield

By: Vickie A. Stewart

Title: Trust Officer

TRUSTEE APPOINTMENT

TIG Insurance Company, as Administrator of the Group and Blanket Accident and Health Insurance Trust, hereby appoints Marine Bank, Springfield, Illinois as Trustee of the Group and Blanket Accident and Health Insurance Trust, effective this 30<sup>th</sup> day of May 2001.

On behalf of TIG Insurance Company

Dated: 6-15-01

By: [Signature]

Attest: [Signature]

ACCEPTANCE OF APPOINTMENT

Marine Bank hereby accepts appointment as Trustee of the Group and Blanket Accident and Health Risk Insurance Trust, effective this 30<sup>th</sup> Day of May, 2001 and agrees to the terms of the Trust Agreement and Declaration of Trust.

On behalf of Marine Bank, Springfield

Dated: 5-30-2001

By: Vickie Stewart T.O.

Attest: Thomas C. Michaels VP+TO

**AMENDMENT #1**  
to  
**THE AGREEMENT AND DECLARATION OF TRUST**  
(the "Agreement")  
with

**Marine Bank, Springfield, Illinois**  
(as the "Trustee")  
and  
**TIG Insurance Company**  
(the "Administrator")

IT IS HEREBY MUTUALLY AGREED, effective as of July 1, 2003, this Agreement shall be amended to include TIG Premier Insurance Company within the defined term, "Administrator". All references to "Administrator" throughout the Agreement shall include both TIG Insurance Company and TIG Premier Insurance Company.

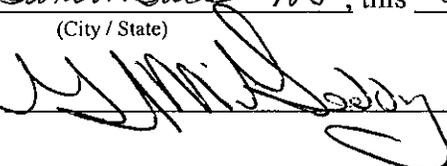
In addition, all notices to the Administrator shall be sent to:

TIG INSURANCE COMPANY / TIG PREMIER INSURANCE COMPANY  
One Hovchild Plaza  
4000 Route 66  
Tinton Falls, New Jersey 07753  
Attention: Robert J. Cody  
Vice President and Associate General Counsel

**IN WITNESS WHEREOF**, the parties hereto have caused this Amendment #1 to be executed by their duly authorized representatives.

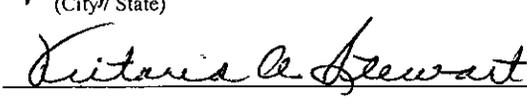
Signed for and on behalf of  
**TIG INSURANCE COMPANY and TIG PREMIER INSURANCE COMPANY**

In Tinton Falls NJ, this 23 day of June, 2003  
(City / State)

By  Title SVP

Signed for and on behalf of **MARINE BANK, Springfield, Illinois**

In Springfield, Illinois this 25th day of June, 2003  
(City / State)

By  Title Trust Officer

**AMENDMENT #2**  
**To**  
**THE AGREEMENT AND DECLARATION OF TRUST**  
**(the "Agreement")**  
**with**

**Marine Bank, Springfield, Illinois**  
**(as the "Trustee")**  
**and**  
**TIG Insurance Company**  
**(the "Administrator")**

IT IS HEREBY MUTUALLY AGREED, effective as of **January 1, 2004**, this Agreement shall be amended to include **Ranger Insurance Company** within the defined term, "Administrator". All references to "Administrator" throughout the Agreement shall include TIG Insurance Company, TIG Premier Insurance Company (as set out in Amendment #1) and Ranger Insurance Company.

In addition, all notices to the Administrator shall be sent to:

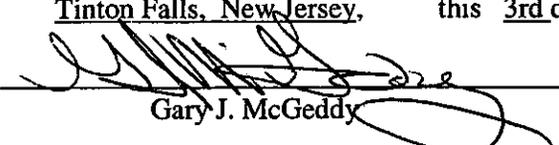
TIG INSURANCE COMPANY  
TIG PREMIER INSURANCE COMPANY  
RANGER INSURANCE COMPANY  
C/o Fairmont Specialty Group  
One Hovchild Plaza  
4000 Route 66  
Tinton Falls, New Jersey 07753

Attention: Robert J. Cody  
Vice President and Associate General Counsel

IN WITNESS WHEREOF, the parties hereto have caused this Amendment #2 to be executed by their duly authorized representatives.

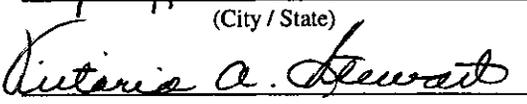
Signed for and on behalf of  
**TIG INSURANCE COMPANY and RANGER INSURANCE COMPANY**

In Tinton Falls, New Jersey, this 3rd day of February, 2004

By  Title: Executive Vice President  
Gary J. McGeddy

Signed for an on behalf of **MARINE BANK, Springfield, Illinois**

In Springfield Illinois this 11th day of February, 2004  
(City / State)

By  Title Trust Officer

AMENDMENT #1  
to  
**THE AGREEMENT AND DECLARATION OF TRUST**  
(the "Agreement")  
with

**Marine Bank, Springfield, Illinois**  
(as the "Trustee")  
and  
**TIG Insurance Company**  
(the "Administrator")

IT IS HEREBY MUTUALLY AGREED, effective as of July 1, 2003, this Agreement shall be amended to include TIG Premier Insurance Company within the defined term, "Administrator". All references to "Administrator" throughout the Agreement shall include both TIG Insurance Company and TIG Premier Insurance Company.

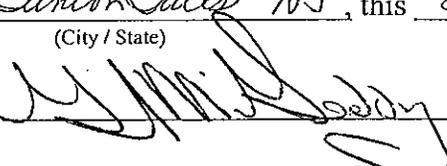
In addition, all notices to the Administrator shall be sent to:

TIG INSURANCE COMPANY / TIG PREMIER INSURANCE COMPANY  
One Hovchild Plaza  
4000 Route 66  
Tinton Falls, New Jersey 07753  
Attention: Robert J. Cody  
Vice President and Associate General Counsel

**IN WITNESS WHEREOF**, the parties hereto have caused this Amendment #1 to be executed by their duly authorized representatives.

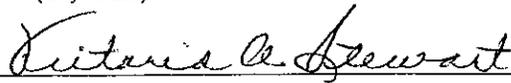
Signed for and on behalf of  
**TIG INSURANCE COMPANY and TIG PREMIER INSURANCE COMPANY**

In Tinton Falls NJ, this 23 day of June, 2003  
(City / State)

By  Title SVP

Signed for and on behalf of **MARINE BANK, Springfield, Illinois**

In Springfield, Illinois this 25th day of June, 2003  
(City / State)

By  Title Trust Officer

**AMENDMENT**  
**To**  
**THE AGREEMENT AND DECLARATION OF TRUST**  
**(The "Agreement")**

**With**  
**Marine Bank, Springfield, Illinois**  
**(As the Trustee)**

**And**  
**TIG insurance Company, TIG Premier Insurance Company, Ranger Insurance Company,**  
**(The Administrator)**

IT IS HEREBY MUTUALLY AGREED, effective as of January 1, 2005, this Agreement shall be amended to acknowledge and agree that TIG Premier Insurance Company has legally changed its name to Fairmont Premier Insurance Company and Ranger Insurance Company has legally changed its name to Fairmont Speciality Insurance Company.

In addition, all notices to the Administrator shall be sent to:

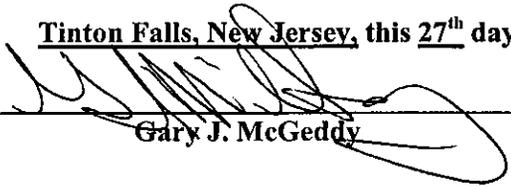
**TIG INSURANCE COMPANY**  
**FAIRMONT PREMIER INSURANCE COMPANY**  
**FAIRMONT SPECIALTY INSURANCE COMPANY**  
**C/o Fairmont Specialty Group**  
**One Hovchild Plaza**  
**4000 Route 66**  
**Tinton Falls, New Jersey 07753**

**Attention: Gary McGeddy**  
**Executive Vice President**

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be executed by their duly authorized representatives.

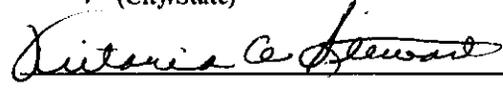
Signed for and on behalf of:  
**TIG INSURANCE COMPANY, FAIRMONT PREMIER INSURANCE COMPANY, and**  
**FAIRMONT SPECIALTY INSURANCE COMPANY**

in Tinton Falls, New Jersey, this 27<sup>th</sup> day of October, 2005.

By:  Title: Executive Vice President  
Gary J. McGeddy

Signed for and on behalf of **MARINE BANK, Springfield, Illinois**

In Springfield IL. this 1st day of 11, 2005  
(City/State)

By:  Title: Trust Officer

**AMENDMENT #2**  
**To**  
**THE AGREEMENT AND DECLARATION OF TRUST**  
**(the "Agreement")**  
**with**

**Marine Bank, Springfield, Illinois**  
**(as the "Trustee")**  
**and**  
**TIG Insurance Company**  
**(the "Administrator")**

IT IS HEREBY MUTUALLY AGREED, effective as of **January 1, 2004**, this Agreement shall be amended to include **Ranger Insurance Company** within the defined term, "Administrator". All references to "Administrator" throughout the Agreement shall include TIG Insurance Company, TIG Premier Insurance Company (as set out in Amendment #1) and Ranger Insurance Company.

In addition, all notices to the Administrator shall be sent to:

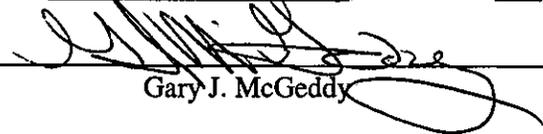
TIG INSURANCE COMPANY  
TIG PREMIER INSURANCE COMPANY  
RANGER INSURANCE COMPANY  
C/o Fairmont Specialty Group  
One Hovchild Plaza  
4000 Route 66  
Tinton Falls, New Jersey 07753

Attention:     Robert J. Cody  
                  Vice President and Associate General Counsel

**IN WITNESS WHEREOF**, the parties hereto have caused this Amendment #2 to be executed by their duly authorized representatives.

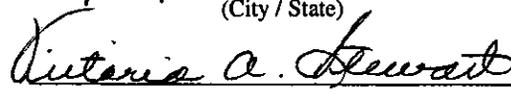
Signed for and on behalf of  
**TIG INSURANCE COMPANY and RANGER INSURANCE COMPANY**

In Tinton Falls, New Jersey, this 3rd day of February, 2004

By  Title: Executive Vice President  
Gary J. McGeddy

Signed for an on behalf of **MARINE BANK, Springfield, Illinois**

In Springfield Illinois this 11th day of February, 2004  
(City / State)

By  Title Trust Officer

**AMENDMENT  
To  
THE AGREEMENT AND DECLARATION OF TRUST  
(The "Agreement")**

**With  
Marine Bank, Springfield, Illinois  
(As the Trustee)**

**And  
TIG insurance Company, TIG Premier Insurance Company, Ranger Insurance Company,  
(The Administrator)**

**IT IS HEREBY MUTUALLY AGREED, effective as of January 1, 2005, this Agreement shall be amended to acknowledge and agree that TIG Premier Insurance Company has legally changed its name to Fairmont Premier Insurance Company and Ranger Insurance Company has legally changed its name to Fairmont Speciality Insurance Company.**

**In addition, all notices to the Administrator shall be sent to:**

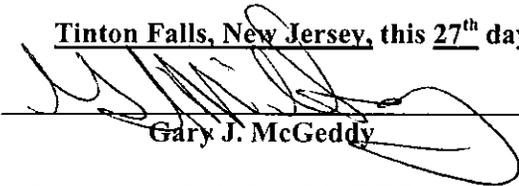
**TIG INSURANCE COMPANY  
FAIRMONT PREMIER INSURANCE COMPANY  
FAIRMONT SPECIALTY INSURANCE COMPANY  
C/o Fairmont Specialty Group  
One Hovchild Plaza  
4000 Route 66  
Tinton Falls, New Jersey 07753**

**Attention: Gary McGeddy  
Executive Vice President**

**IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be executed by their duly authorized representatives.**

**Signed for and on behalf of:  
TIG INSURANCE COMPANY, FAIRMONT PREMIER INSURANCE COMPANY, and  
FAIRMONT SPECIALTY INSURANCE COMPANY**

**in Tinton Falls, New Jersey, this 27<sup>th</sup> day of October, 2005.**

**By:  Title: Executive Vice President**  
**Gary J. McGeddy**

**Signed for and on behalf of MARINE BANK, Springfield, Illinois**

**In \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_,  
(City/State)**

**By: \_\_\_\_\_ Title: \_\_\_\_\_**

**AMENDMENT**  
**To**  
**THE AGREEMENT AND DECLARATION OF TRUST**  
**(The "Agreement")**  
**With**  
**Marine Bank, Springfield, Illinois**  
**(As the Trustee)**  
**And**  
**TIG Insurance Company, TIG Premier Insurance Company, Ranger Insurance Company,**  
**(The Administrator)**

IT IS HEREBY MUTUALLY AGREED, effective as of January 1, 2006, that the Agreement shall be amended to include United States Fire Insurance Company, The North River Insurance Company, and Crum & Forster Indemnity Company within the defined term "Administrator".

**In addition, all notices to the Administrator shall be sent to:**

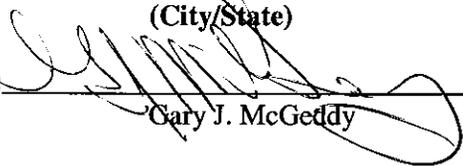
Fairmont Specialty  
5 Christopher Way  
Eatontown, New Jersey 07724

Attention: Gary McGeddy  
Executive Vice President

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be executed by their duly authorized representatives.

**Signed for and on behalf of:** Fairmont Premier Insurance Company, Fairmont Specialty Insurance Company, and TIG Insurance Company.

**In:** Eatontown, New Jersey this 14th day of December, 2005.  
(City/State)

**By:**  **Title:** Executive Vice President  
Gary J. McGeddy

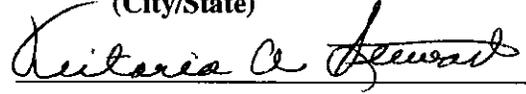
**Signed for and on behalf of:** United States Fire Insurance Company, The North River Insurance Company, and Crum & Forster Indemnity Company.

**In:** Morristown, New Jersey this 9th day of December, 2005.  
(City/State)

**By:**  **Title:** Vice President and Secretary

**Signed for and on behalf of MARINE BANK, Springfield, Illinois**

**In:** Springfield IL this 23rd day of December, 2005.  
(City/State)

**By:**  **Title:** Trust Officer

## CONSUMER INFORMATION NOTICE

You may contact United States Fire Insurance Company at:

United States Fire Insurance Company  
5 Christopher Way  
3<sup>rd</sup> Floor  
Eatontown, NJ 07724  
1-800-232-7380

You may contact the Arkansas Insurance Department at:

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904  
1-800-852-5494 or 501-371-2640

(If applicable)

You may contact your Agent at:

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**WESTMONT  
ASSOCIATES, INC.**

November 19, 2010

via *SERFF*

The Honorable Julie Benafield Bowman  
Commissioner of Insurance  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
*Attention: Life & Health Division*

**Re: United States Fire Insurance Company**  
**FEIN#: 13-5459190**  
**NAIC#: 0158-21113**

<b>Occupational Accident Policy</b>	<b>Form Number AH27700</b>
<b>Certificate of Insurance</b>	<b>Form Number AHC27700</b>
<b>Participation Agreement</b>	<b>Form Number AH27400-PA</b>
<b>Application</b>	<b>Form Number DA-27700</b>
<b>Owner/Operator Request for Insurance</b>	<b>Form Number AH27440-ORQ</b>
<b>Dependent Coverage Rider</b>	<b>Form Number AHE-27700-DR-AR</b>
<b>Coma Benefit Rider</b>	<b>Form Number AHE- 27700-CCR</b>
<b>Emergency Evacuation Benefit Rider</b>	<b>Form Number AHE-27700- EER</b>
<b>Felonious Assault Benefit Rider</b>	<b>Form Number AHE-27700-FBR</b>
<b>Hemorrhoid Benefit Rider</b>	<b>Form Number AHE-27700-HBR</b>
<b>Hernia Benefit Rider</b>	<b>Form Number AHE-27700-Hernia Rider</b>
<b>Hijacking Benefit Rider</b>	<b>Form Number AHE-27700- Hijacking Benefit Rider</b>
<b>Home Alteration and Vehicle Modification Benefit Rider</b>	<b>Form Number AHE-27700-HAVM</b>
<b>In-Hospital Indemnity Benefit Rider</b>	<b>Form Number AHE-27700-IHI</b>
<b>Natural Disaster Benefit Rider</b>	<b>Form Number AHE-27700-NDB</b>
<b>Passenger Coverage Rider</b>	<b>Form Number AHE-27700-PE</b>
<b>Rehabilitation Benefit Rider</b>	<b>Form Number AHE-27700-RB</b>
<b>Seat Belt and Airbag Benefit Rider</b>	<b>Form Number AHE-27700-SBAB</b>
<b>Trauma Counseling Benefit Rider</b>	<b>Form Number AHE-27700-TCB</b>
<b>Arkansas Amendatory Endorsement</b>	<b>Form Number AHE-27700-AR</b>

Honorable Commissioner Bowman:

I respectfully submit the form filing referenced above on behalf of United States Fire Insurance Company ("United States Fire") for your review and approval prior to use in your state. Westmont Associates, Inc. has been requested to file these forms on behalf of United States Fire. Please see the enclosed authorization letter.

This is a trust filing utilizing the Group and Blanket Accident & Health Insurance Trust (the "Trust") as originally agreed to by TIG Insurance Company (the Administrator) and Marine Bank, Springfield, Illinois (the Trustee) and dated May 30, 2001. A copy of the Trust Agreement is provided for your reference. By Amendment dated January 1, 2006, the Trust Agreement was amended to include United States Fire as "Administrator". Insurance contracts will be issued to the Trustee for the benefit of participants that have been approved for such insurance. This Trust has been utilized in several previous United States Fire filings in Illinois and was approved.

Occupational Accident Policy, Form #AH27700, covers a broad class of persons for specific losses related to specific activities. The subject forms are new and are not intended to replace any other forms currently in use.

Occupational Accident Policy, Form #AH27700, provides accident benefits on generally a voluntary blanket basis to participants (e.g., motor carriers or other participating organizations) to cover non-employee independent contractors. However, coverage or supplemental coverage may also be provided on a non-contributory basis. United States Fire files these forms as variable; offering accidental death and dismemberment benefits, disability income benefits, and accident medical/dental expense benefits either separately or in combination. The forms as filed are more inclusive than the forms as they will be issued on a specific case or program. Variable data is bracketed and italicized and may vary on a case or program basis. Please see the enclosed Statements of Variability for United States Fire's explanation of how these forms may vary to accommodate different product offerings

The Certificate of Insurance, Form #AHC27700, will be issued to describe the plan of benefits offered when required by law or as requested by the Participating Organization.

By the Application, Form #DA27700, the Group and Blanket Accident & Health Insurance Trust will request that United States Fire provide insurance under the aforementioned Policy.

By the Participation Agreement, Form #AH277400-PA, the participating organization will apply to United States Fire to participate in the Group and Blanket Accident & Health Insurance Trust. Such participation entitles the organization to coverage for its Independent Contractors under the said Trust.

The Request for Insurance, Form # AH27440-ORQ, identifies the person(s) covered and detail the benefits applicable to such persons covered and will be signed by the Owner/Operator.

The Riders listed may be selected at the option of the Participating Organization.

The Occupational Accident Insurance product will be marketed by licensed agents, brokers, and third party administrators to eligible participating organizations.

In accordance with Arkansas' filing requirements, enclosed please find:

- Letter of Authorization
- Readability Certification, excluding the state mandated language

endorsement, form # AH27000-AR

- Forms
- Statements of Variability
- Consumer Information Notice
- Trust Agreement
- Life & Health Guaranty Association Act Notice to Policyholders

I thank you in advance for the time spent on this filing and trust that you will find everything in order. Please do not hesitate to contact me directly at 856-216-0220, x 221 or at [Darcy@Westmontlaw.com](mailto:Darcy@Westmontlaw.com) if you have any questions or require additional information.

Respectfully,

***Darcy Lebau***

Darcy Lebau

SERFF Tracking Number: WESA-126907653 State: Arkansas  
 Filing Company: United States Fire Insurance Company State Tracking Number: 47357  
 Company Tracking Number: AH27700  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: United States Fire Occupational Accident  
 Project Name/Number: United States Fire Occupational Accident/AH27700

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/16/2010	Form	CERTIFICATE OF INSURANCE	11/29/2010	Certificate11-3-10.docCLEAN11102010.pdf (Superseded)
11/16/2010	Form	DEPENDENT COVERAGE RIDER	11/29/2010	Dependent Coverage Rider 11-3-10.docCLEANAR.pdf (Superseded)
11/17/2010	Form	ARKANSAS AMENDATORY ENDORSEMENT	11/29/2010	AR Rider OA.docv4.pdf (Superseded)

# UNITED STATES FIRE INSURANCE COMPANY

(Herein Called "We, "Our", or "Us")

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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## CERTIFICATE OF INSURANCE

This Certificate of Insurance is issued under the terms of the Policy issued to the Policyholder. We insure each person in one of the Eligible Classes provided the application is received and the required premium is paid when due.

We will pay the benefits described in this Certificate for certain losses resulting directly and independently of all other causes from an Injury sustained in an Occupational Accident that occurs while the Policy is in force and Your coverage is in effect. Your insurance is subject to all the provisions, conditions, exclusions and limitations of the Policy.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Signature



Douglas M. Libby  
Chairman and CEO

Signature



James Kraus  
Secretary

### IMPORTANT NOTICE

**THIS IS A CERTIFICATE FOR OCCUPATIONAL ACCIDENT BENEFITS ONLY. BENEFITS ARE NOT PAID FOR SICKNESS OR ANY OTHER TYPE OF INJURY. THIS POLICY IS NOT WORKERS' COMPENSATION INSURANCE AND DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

**[Arizona Residents: NOTICE: THIS CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL THE BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THIS CERTIFICATE CAREFULLY.]**

**[Florida Residents: The Benefits of the policy providing *Your* coverage are governed primarily by the law of a state other than Florida.]**

**[Texas Residents:**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM. THIS INSURANCE DOES NOT RELIEVE AN EMPLOYER OF WORKERS' COMPENSATION COVERAGE OBLIGATIONS.**

**[West Virginia Residents: **Right to Return** – *You* have the right to return this Certificate to us or our agent for cancellation within 10 days of its delivery to you. The full amount of *Your* premium will be refunded to *You*, if, after examination of this certificate *You* are not satisfied for any reason.]**

**PLEASE READ THIS CERTIFICATE CAREFULLY.**

**TABLE OF CONTENTS**

SCHEDULE OF BENEFITS ..... [2  
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT ..... 6  
DISABILITY INCOME BENEFIT ..... 8  
ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT ..... 10  
GENERAL EXCLUSIONS ..... 15  
CLAIMS INFORMATION..... 16  
GENERAL PROVISIONS REGARDING AN INDIVIDUAL'S COVERAGE ..... 18  
DEFINITIONS..... 20]

## SCHEDULE OF BENEFITS

This Schedule of Benefits is a very brief summary of Your benefits. A more complete description of the benefits is in this Certificate.

**Policyholder:** [The Group and Blanket Accident & Health Insurance Trust]

**Policy Number:** [AH27700-006]

**Participant:** [XYZ Motor Carrier]

**Participant's Effective Date:** [date]

**Participant's Anniversary Date:** [date] and each [date] thereafter.

**Insured:** [John Doe.]

**Social Security Number:** [000-00-0000]

**Insured's Effective Date:** [date]

### Eligible Classes:

[Class 1	Owner/Operator
Class 2	Scheduled Co-Driver
Class 3	Scheduled Contract Driver of Owner/Operator
Class 4	Scheduled Laborer]

All references to "You" or "Your" in this Certificate means the Insured who is included in an Eligible Class. Coverage is provided to a person in an Eligible Class under this Certificate **ONLY** under the following circumstances:

**As an Owner/Operator:** You will be covered only while:

- (a) You are Under Contract to the Participant and performing Your contractual obligations under that contract; and
- (b) You are not on a Personal Deviation. "Personal Deviation" means:
  1. an activity that is not reasonably related to the Participant's business/Participant's activities; and
  2. not incidental to the performing Your contractual obligations.

**[If You are in an Eligible Class other than Owner/Operator:** You will be covered only:

- (a) If an Insured Owner/Operator has submitted a Request to cover You;
- (b) The Insured Owner/Operator's Request has been accepted by Us;
- (c) You are Under Contract to the Participant or Owner/Operator and performing Your contractual obligations under that contract; and
- (d) You are not on a Personal Deviation. "Personal Deviation" means:
  1. an activity that is not reasonably related to the Participant's or Owner/Operator's business activities; and
  2. not incidental to the performing Your contractual obligations.]

**Required Waiting Period:** No waiting period for Accident Medical/Dental Expense. See other Benefits for any Waiting Period specific to the Benefit.

**Who Pays For the Coverage:** [You must pay the cost of Your coverage under this Plan.]

**Premium Due Date:** [The 1<sup>st</sup> of each month]

**Age Limit:** You will not be covered after You reach age [65]

**SCHEDULE OF BENEFITS  
(Continued)**

**COVERAGE PROVIDED**

**Occupational Accident:** Covered  
**[Occupational Disease:** Covered]  
**[Cumulative Trauma:** Covered]  
**[Hernia:** Covered]  
**[Non-Occupational Accident:** See Endorsement Attached]  
**[Dependent Coverage:** See Endorsement Attached]

**[INSTALLMENT PAYMENT OPTION ELECTED FOR DEATH BENEFITS: \_\_\_ YES \_\_\_ NO]**

**AMOUNTS OF INSURANCE**

<b>Class</b>	<b>Accidental Death and Dismemberment Principal Sum</b>	<b>Temporary Total Disability Weekly Benefit</b>	<b>Permanent Total Disability Monthly Benefit</b>	<b>Accident Medical/Dental Expense Benefit Maximum Benefit</b>
[1	\$50,000	(a)	(b)	\$100,000 per accident
2	\$50,000	(a)	(b)	\$100,000 per accident
3	\$25,000	(a)	(b)	\$100,000 per accident
4	\$10,000	(a)	(b)	\$100,000 per accident]
[(a)	70% of Average Weekly Earnings, subject to a maximum amount of \$500 per week [minus Other Income Benefits].			
(b)	4.3 times Average Weekly Earnings multiplied by 0.70, subject to a maximum amount of \$1,505 per month minus Other Income Benefits.]			

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

**Time Limit For Loss:** [180] [365] days from date of the Occupational Accident]

**TOTAL DISABILITY BENEFITS**

**Daily Benefit**

Temporary Total Disability – [1/7th of the Weekly Benefit]

Permanent Total Disability- [1/30th of the Monthly Benefit]

**Benefit Waiting Period**

Temporary Total Disability- [7 days of continuous Total Disability ]

Permanent Total Disability- [180 days of continuous Total Disability]

**[Maximum Payment Period**

Temporary Total Disability- 26 weeks  
 Permanent Total Disability- 60 months]

**[Reduction in Disability Income Benefits**

The amount of Your Temporary Total or Permanent Total Disability Income Benefits will be reduced by the amount of any [Other Income Benefits / Social Security benefits] payable to You on account of such disability. This amount will include any benefits payable for Your dependents. Cost-of-living increases in Social Security payments effective after Your correct Social Security benefit has been determined will not be used to reduce Your Disability Income Benefit.]

**SCHEDULE OF BENEFITS  
(Continued)**

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFITS**

**Time Limit for Loss**

Treatment must begin within [30][60][90] days from the date of Injury in a covered Occupational Accident.

**Maximum Payment Period**

Benefits are payable for [[6] [12] months] [[52][104] weeks] from the date of the covered Injury. The Injury must occur after the Effective Date and prior to the Expiration Date and care must be Appropriate Care.

**[Deductible**

[\$50] per Covered Person per Occupational Accident]

**Coinsurance Rate**

[100%] of Reasonable Charges

**[COMBINED SINGLE BENEFIT LIMIT**

Not more than [\$1,000,000] will be paid under **all benefits** (Accidental Death and Dismemberment, Disability Income and Accident Medical/Dental Expense Benefits combined) for any one person due to any one Occupational Accident.]

**[ADDITIONAL BENEFITS** – See Endorsement(s) Attached]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

**[This benefit is subject to the Combined Single Benefit Limit shown in the Schedule of Benefits.]**

If You have an Occupational Accident while covered under the Policy, We will pay the Percent of the Principal Sum shown below for the Covered Loss named below. To be covered the loss must meet all of the following requirements:

- (1) The loss must be the direct result of an Injury sustained in an Occupational Accident.
- (2) The Occupational Accident must occur while You are covered under this Policy.
- (3) The loss must occur within the Time Limit shown in the Schedule of Benefits.

The Principal Sum is shown in the Schedule of Benefits. Only one benefit, the highest, will be paid if You suffer more than one Covered Loss in an Occupational Accident.

<b>Covered Loss</b>	<b>Percent of Principal Sum</b>
[Life.....]	100%
Both Hands, Both Feet, or Sight of Both Eyes .....	100%
Any combination of Foot, Hand or Sight of One Eye.....	100%
Speech and Hearing in Both Ears .....	100%
Use of Both Arms and Both Legs.....	100%
Use if One Arm and One Leg on One Side of the Body.....	75%
Use if Both Arms or Both Legs .....	75%
One Hand, One Foot or Sight of One Eye.....	50%
Speech .....	50%
Hearing in One Ear.....	25%
Thumb and Index Finger of Same Hand.....	25%]

[Loss of Hand means removal at or above the wrist joint.] [Loss of Foot means removal at or above the ankle joint.] [Loss of Sight means total loss of sight that cannot be recovered.] [Loss of Speech means total loss of speech that cannot be recovered.] [Loss of Hearing means total loss of hearing that cannot be recovered.] [Loss of Use means complete paralysis of the entire limb that cannot be recovered. A Physician must determine the loss of use to be complete and not reversible at the time the claim is submitted.] [Loss of Thumb and Index Finger means removal at or above the last joint of both.]

Benefits for loss of life are paid to Your beneficiary. Benefits for other losses are paid to You.

**Beneficiary**

You have the right to change Your beneficiary and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary. A beneficiary may be changed by filling out a Change of Beneficiary form. You can get this form from the Participant. The form must be received and recorded by the Participant before the change of beneficiary becomes effective.

**Not Covered**

No payment will be made for any loss caused or contributed to by the following:

- (1) Disease, bodily or mental infirmity, functional nervous or emotional disorders, with or without a demonstrable organic cause, or any medical or surgical treatment, or diagnostic procedures for any of these, or for any condition or treatment that is not the direct result of an injury sustained in a covered Occupational Accident,
- (2) Ptomaine or bacterial infection, other than pyogenic or bacterial infection occurring as a consequence of an accidental cut or wound sustained in an Occupational Accident.

Other exclusions that apply to this benefit are in **General Exclusions.]**

## **[DISABILITY INCOME BENEFIT**

**[This benefit is subject to the Combined Single Benefit Limit shown in the Schedule of Benefits.]**

If You become Totally Disabled due to an injury sustained in an Occupational Accident that happens while covered under the Policy, You will be paid the benefits described below.

You must satisfy the Benefit Waiting Period and be under the Appropriate Care of a Physician. You must provide Us with satisfactory proof of Your Total Disability, at Your expense, before benefits will be paid. We will require continued proof of Your Total Disability be provided from time to time at Your expense for benefits to continue.

### **Temporary Total Disability**

Payments will start as shown in the Schedule of Benefits. Payments will stop on the earliest of the following:

- (1) The date Your Total Disability stops.
- (2) The date You return to work unless Your return to work qualifies You for Partial Disability Benefits as described in the Policy.
- (3) When the Maximum Payment Period for Temporary Total Disability shown in the Schedule of Benefits is reached.
- (4) The date You reach the Age Limit shown in the Schedule of Benefits.

### **[Partial Disability Benefit**

If You return to Your regular occupation on a part-time basis, or any other occupation on a full-time or part-time basis, Your Temporary Total Disability Benefits will be reduced. For any week, if the sum of Your Temporary Total Disability Benefit, current earnings and any additional Other Income Benefits exceed 100% of Your Average Weekly Earnings, Your Temporary Total Disability Benefit will be reduced by the excess amount.]

### **Permanent Total Disability**

Payments will start on the latest of:

- (1) The date You satisfy the Benefit Waiting Period shown in the Schedule of Benefits for this benefit.
- (2) The first day of the week after the Maximum Payment Period under Temporary Total Disability is reached.
- (3) The date You are granted a Social Security Disability Award for the Total Disability.

Payments will stop on the earliest of the following:

- (1) The date Your Total Disability stops.
- (2) The date You return to work.
- (3) When the Maximum Payment Period for Permanent Total Disability shown in the Schedule of Benefits is reached.
- (4) The date You reach the Age Limit shown in the Schedule.
- (5) The date Your Social Security Disability Award stops.

### **MAXIMUM PAYMENT PERIODS**

The Maximum Payment Periods shown in the Schedule of Benefits are for each period of disability.

**DISABILITY INCOME BENEFIT**  
**(Continued)**

**SUCCESSIVE PERIODS OF DISABILITY**

Once You are Totally Disabled under the Policy, separate periods of Total Disability resulting from the same or related causes are a continuous period of Total Disability unless You return to work for at least 6 months between periods of Total Disability. Only one Benefit Waiting Period and Maximum Payment Period apply to any one period of continuous Total Disability.

A period of Total Disability is not continuous if separate periods of Total Disability result from unrelated causes, or Your later Total Disability occurs after Your coverage under the Policy ends. This provision will not apply if You are eligible for coverage under a plan that replaces the Policy.

**Not Covered**

No payment will be made for any Total Disability for which benefits are payable under any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted.

Other exclusions that apply to this benefit are in **General Exclusions.**]

**[ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT**

**[This benefit is subject to the Combined Single Benefit Limit shown in the Schedule of Benefits.]**

The Accident Medical Expense Benefit provides payment for the Covered Expenses shown below. These expenses must be charged to You while covered. These expenses must be ordered by a Physician as Medically Necessary for Injuries that result directly and from no other causes from an Occupational Accident. [These benefits are subject to the Deductible, Coinsurance Rate, Maximum Payment Periods, and Maximum Benefits shown in the Schedule of Benefits.]

**Maximum Benefit**

The Maximum Benefit for any one Occupational Accident is shown in the Schedule of Benefits.

**Covered Expenses**

Covered Expenses are the actual cost to You of the Reasonable Charges for the services and supplies listed below. The service or supply must be:

- (1) Ordered by a Physician for the diagnosis or treatment of an Occupational Accident.
- (2) Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We, at our discretion, may consider the cost of that alternative to be Covered Expenses. In this case, Covered Expenses are limited to the Reasonable Charges for that diagnostic or treatment alternative.

We pay Covered Expenses:

- (1) after the Covered Person satisfies any deductible; and
- (2) [only when they are in excess of amounts paid by any other Health Care Plan, except for the first \$100 of claims.]  
[We pay benefits without regard to any coordination of benefits provisions in any other Health Care Plan.]

Covered Expenses include:

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT  
(Continued)**

**[Ambulance Services**

Transportation for a Medical Emergency

- (1) By professional ambulance, other than air ambulance, to and from a Hospital.
- (2) By regularly scheduled airline, railroad or air ambulance to the nearest Hospital qualified to give the required treatment.

These services must be given within the United States or Canada.]

**[Ambulatory Surgical Center Charges**

Medically Necessary charges for a Center's services given on the day of a surgical procedure. The services have to be given in connection with the procedure.]

**[Anesthetics**

Anesthetics and charges for giving them.]

**[Dental Services**

Coverage for dental services is limited to the following as the result of an Occupational Accident that happens while covered:

- (1) Appliances and splints placed on or attached to natural teeth.
- (2) Full or partial dentures.
- (3) Fixed bridgework if needed because of Occupational Accidental injury to natural teeth.
- (4) Prompt repair to natural teeth if needed because of Occupational Accidental injury to those teeth.]

**[Health Care Provider's Services**

Services of a licensed or certified Health Care Provider acting within the scope of that license or certification. Covered Expenses given by a Health Care Provider are payable on the same basis as Covered Expenses given by a Physician.]

**[Hospital Charges**

The daily room rate when a You are confined in a Hospital, general nursing care provided and charged for by the Hospital, and ancillary Hospital expenses for services and supplies, including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) while You are confined in a Hospital.]

**[Laboratory Tests and X-rays**

X-rays or tests for diagnosis or treatment.]

**[Medical Supplies**

- (1) Prescribed drugs and medicines.
- (2) Surgical supplies (such as bandages and dressings).
- (3) An appliance that replaces a lost body organ or part or helps an impaired one to work. An appliance will be replaced only if damaged as the result of an Occupational Accident that happens while covered.
- (4) Oxygen and charges for giving it. This includes rental of required equipment.
- (5) Rental of a wheel-chair or hospital-type bed.
- (6) Rental of a device to help breathing when paralyzed.]

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT  
(Continued)**

**[Nursing Services**

Services of a trained nurse. The services of a private duty nurse, while You are confined in a hospital, may not always be deemed Medically Necessary. In any case when such services are not deemed Medically Necessary, charges made by a private duty nurse will not be considered Covered Expenses. No benefits will be paid for such private duty nursing.]

**[Occupational Therapy**

Services for medical care and treatment by an occupational therapist practicing in the scope of their license.]

**[Physician's Services**

- (1) Medical Care and Treatment.
- (2) Hospital, office and home visits.
- (3) Emergency room treatment services.
- (4) Surgery.
- (5) Services for surgical procedures.
- (6) Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of
  - (a) surgery to treat an Occupational Accidental injury that happens while You are covered under this Plan.
  - (b) Reconstructive surgery to remove scar tissue due to an Occupational Accidental injury that happens while You are covered under this Plan.

Assistant Surgeon Services are limited to 1/5 of the amount of Covered Expenses for the surgeon's charge for the surgery.

If You undergo more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- (1) For the second procedure, to [50%] of the Covered Expenses for the secondary procedure.
- (2) For any subsequent procedure, to [25%] of the Covered Expenses for the subsequent procedure.]

**[Physiotherapy**

When rendered by a Physician, as defined, for any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; limited to one visit per day.

**[Skilled Home Health Care**

Services given by a Home Health Care Agency. The following items are covered to the extent that they would have been covered under this benefit if You had stayed in the hospital.

- (1) Medical supplies.
- (2) Drugs and medications ordered by a Physician.
- (3) Laboratory services given or ordered by a hospital.

The care has to be ordered in writing and supervised by a Physician. [Payment for Skilled Home Health Care will be limited to the first 80 visits for each Occupational Accident.]]

**[Skilled Nursing Facility Charges**

Room and Board and Other Services and Supplies. Charges will be counted as Covered Expenses up to the facility's regular daily charge for a semi-private room. [Payment for Skilled Nursing Facility charges will be limited to the first 120 days of confinement for each Occupational Accident.] The care has to be supervised by a Physician. ]

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT**  
**(Continued)**

**[Speech Therapy**

Speech therapy given to restore speech. The speech must have been lost or impaired due to Occupational Accidental injury that happens while You are covered under this Plan.]

**[Not Covered**

- (1) Services or supplies that are not Medically Necessary, including any confinement, treatment, service or supply given in connection with a service or supply that is not Medically Necessary.
- (2) Care of and treatment to the teeth and gums is not covered except for those services specifically named in this benefit.
- (3) Eye glasses, eye refractions and hearing aids, unless required by an Occupational Accident that happens while covered.
- (4) Injury caused by war or international armed conflict.
- (5) Services given by any of the following persons:
  - (a) A member of Your immediate family; or who resides in Your home.
  - (b) Volunteers or persons who do not normally charge for their services.
- (6) Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home
- (7) Drugs, treatments, services or supplies that are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinement, treatment, service or supplies.
- (8) Cosmetic or reconstructive surgery or treatment (surgery or treatment primarily to change appearance) whether or not for psychological or emotional reasons. This exclusion does not apply to reconstructive surgery specifically named in the Plan.
- (9) Custodial Care. This is care made up of services and supplies that meets one of the following conditions:
  - (a) Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
  - (b) Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.Care that meets one of the conditions above is custodial care regardless of any of the following:
  - (i) Who recommends, provides or directs the care.
  - (ii) Where the care is provided.
  - (iii) Whether or not the patient can be or is being trained to care for him or herself.
- (10) Treatment in a United States government or agency hospital. However, the reasonable cost incurred by the United States for medical care and treatment for a non-service connected disability given to a veteran by the United States or one of its agencies is covered to the extent the care and treatment is otherwise covered under the Plan. (This exclusion does not apply in Minnesota.)
- (11) Expenses for which You are not legally required to pay.(This exclusion does not apply to charges made by a hospital owned or operated by the states of Minnesota, Oregon or West Virginia.)
- (12) Private duty nursing services that is not Medically Necessary. In most cases, private duty nursing while confined in a Hospital is not Medically Necessary.

**ACCIDENT MEDICAL/DENTAL EXPENSE BENEFIT  
(Continued)**

- (13) Charges made by a Hospital for Room, Board or Other Fees during a confinement in an area of the Hospital that is used as a special care area, by whatever name called. A special care area is any area of a Hospital that renders services on an in-patient basis for other than acute care of sick or injured persons. Benefits for a covered facility that is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

Other exclusions that apply to this benefit are in **General Exclusions.]**

**GENERAL EXCLUSIONS**

In addition to the exclusions listed in specific benefit sections, this Plan does not cover any loss:

- (1) Covered by any workers' compensation, employers' liability, occupational disease or similar law.
- (2) Resulting from an intentionally self-inflicted injury.
- (3) Resulting from suicide or attempted suicide, while sane or insane (while sane in Missouri).
- (4) Resulting from boarding or alighting from any aircraft in motion.
- (5) Resulting from war or act of war; whether declared or not.
- (6) Resulting from duty in the armed forces of any country or international authority.
- (7) Resulting from the Insured being under the influence of any narcotic unless administered on the advice of a Physician and taken as prescribed, or being intoxicated as defined by the state where the Injury occurs.
- (8) That is psychological or emotional in nature, including pain and suffering.
- (9) Resulting from Cumulative Trauma (see Definitions), unless specifically shown as "Covered" in the Schedule of Benefits.
- (10) Resulting from Occupational Disease (see Definitions), unless specifically shown as "Covered" in the Schedule of Benefits.
- (11) To which a contributing cause was the commission of or attempt to commit a felony by the Insured whose injury or sickness is the basis of the claim, or to which a contributing cause was such person's being engaged in an illegal occupation or activity.

**NON-DUPLICATION OF WORKERS' COMPENSATION BENEFITS**

No benefits are payable under this Plan for any loss for which You claim benefits as an employee under any workers' compensation, occupational disease or similar law. If You claim benefits under this Plan and, at a later date, claim benefits for the same loss under any workers' compensation, occupational disease or similar law or benefit plan, We have the right to recover from You the amount of the benefits paid for such loss under this Plan.

## CLAIMS INFORMATION

### Assignment

This coverage may not be assigned. Benefit payments may be assigned at the time of claim. Any payment made by Us in good faith will end Our liability to the extent of the payment.

### Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to [Us at 5 Christopher Way, 3<sup>rd</sup> Floor, Eatontown, NJ 07724] [our Administrator at [address]] or to any authorized agent of Ours, with information sufficient to identify the insured Participant, shall be deemed notice to Us.

### Claim Forms

We, upon receipt of a written notice of claim, will furnish to the Participant such forms as are usually furnished by Us for filing proofs of loss. If forms are not furnished within 15 days after the giving of such notice the Insured shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### Proof of Loss

Written proof of loss must be furnished to Us, in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one year from the time proof is otherwise required.

### Time of Payment of Claims

Indemnities payable under the Policy for any loss other than loss for which this policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which the Policy provides periodic payment will be paid and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

### Payment of Claims

Indemnity for loss of life will be payable in accordance with the Beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured . Any other accrued indemnities unpaid at the Insured's death may, at the option of the Insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured.

If any indemnity of this policy shall be payable to the estate of the Covered Person, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Insurer may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Insurer to be equitably entitled thereto. Any payment made by the Insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

## **CLAIMS INFORMATION (Continued)**

Subject to any written direction of the Insured in an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at the Insurer's option, and unless the Insured requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

### **Physical Examination and Autopsy**

We, at Our own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as We may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death, where it is not forbidden by law. (This provision does not apply to residents of Mississippi.)

### **Legal Actions**

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas; 6 years in South Carolina) after the time written proof of loss is required to be furnished.

### **Facility of Payment**

Whenever payments that should have been made under this Policy are made by any other policy, We shall have the right, exercisable at Our sole discretion, to pay over to any plan making such other payments any amounts We shall determine are warranted in order to satisfy the intent of this provision. The amounts so paid shall be considered benefits paid under this Policy and, to the extent of such payments, We shall be fully discharged from liability under this Policy.

### **Subrogation/Right of Recovery**

You must refund to Us any overpayment of benefits that occurs because a third party was liable to pay certain of Your expenses due to a wrongful act, negligence or omission. The refund will equal the amount We paid under this Plan. If the refund is due from another person or organization, You must help Us obtain the refund. We also have the right to pursue a refund or recovery even if You do not do so. This is called subrogation. You must help Us use this right when requested. The amount of the recovery will be reduced by a proper share of the legal fees and expenses needed to obtain the refund.

### **Claimant Cooperation Provision**

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

### **Fraud Warning**

Any person who knowingly, and with intent to defraud or deceive Us or any other person, makes a Request for Insurance or any claim for the proceeds of the Policy containing any false, incomplete or misleading information may be guilty of a crime. In New York, any person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

### **Conformity With State Law**

If any provision of the Policy or Certificate is in conflict with the laws in the state where it is issued it is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS REGARDING AN INDIVIDUAL'S COVERAGE

### Who Is Eligible For Coverage

Each person in one of the Eligible Classes shown in the Schedule of Benefits is eligible to be insured on the latest of:

- (1) the Policy Effective Date;
- (2) the Participant's Effective Date; or
- (3) the day after he or she completes the Eligibility Waiting Period, if later].

We maintain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

### When Coverage Starts

Coverage under this Plan starts only after a Request for Insurance form is filed with and approved by Us and the required premium for coverage is paid.

### How to File a Request

Ask the Participant [(Owner/Operator if You are a Co-Driver, Helper or Contract Driver)] for a Request for Insurance form. It must be completed and filed with Us.

Coverage goes into effect on the latest of:

- (1) the Participant's Effective Date shown in the Schedule of Benefits.;
- (2) the date You are included in an Eligible Class and complete any Eligibility Waiting Period shown in the Schedule of Benefits.
- (3) the date We receive Your completed Request for Insurance form; or
- (4) the date the required premium is received by Us.

[If You are not working because You are disabled on the date coverage would start, coverage will not start until You are no longer disabled and return to work.]

### When Coverage Stops

Coverage will stop on the earliest of:

1. the date You are no longer in an Eligible Class;
2. the end of the period for which You paid premiums;
3. the date the Participant's coverage ends;
4. the date the Policy ends;
5. the date You attain the Age Limit shown in the Schedule of Benefits.

When Your coverage ends it will not affect a claim for a covered loss due to an Occupational Accident that happened while the coverage was in effect.

**Grace Period:** A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but You shall be liable to Us for the payment of the premium accruing for the period the policy continues in force. We may deduct from any claims otherwise payable any premium that is outstanding from the 31-day period.

### Benefits Available After Coverage Stops

#### Accidental Death and Dismemberment Benefits

We will pay these benefits if the loss happens within the Time Limit shown in the Schedule of Benefits after an Occupational Accident that occurs while You are covered under the Policy.

### **Disability Income Benefits**

If a Covered Person is Totally Disabled on the date coverage ends, We will pay benefits for that period of disability. Benefits will be paid for up to the Maximum Payment Period shown in the Schedule of Benefits, less the number of days paid before the date coverage stopped. Benefits will end earlier if the Covered Person is no longer Totally Disabled.

### **[Accident Medical/Dental Expense Benefits**

We will extend benefits under the Policy after a Covered Person's coverage would otherwise end if on that date he or she is under a Physician's care for a condition covered by the Policy for up to [90] days. Any benefits payable under this provision will not exceed the benefit maximums for this benefit shown in the Schedule of Benefits.]

## **DEFINITIONS**

### **[Appropriate Care**

The determination of an accurate and medically supported diagnosis of Your Total Disability, or ongoing medical treatment and care of Your disability by a Physician that conforms to generally-accepted medical standards, including frequency of treatment and care.]

### **[Average Weekly Earnings**

[Your prior year's taxable income or wages as reported for Federal Income Tax purposes, provided Your occupation was essentially the same as Your current occupation, divided by 52 or the number of weeks actually worked if less than 52.]

[Your average weekly earnings are the average payments made to You by the Participant or Covered Owner/Operator for work performed while transporting the Participant's cargo. Average weekly earnings will not include any performance bonus, expense reimbursement or other extra or additional payments of any kind. Average weekly earnings will be determined as the average of such payments over the shorter of:

- (1) The 104 weeks immediately prior to the date Total Disability began; or
- (2) The period worked.]

### **[Benefit Waiting Period**

The period of time You must be continuously Totally Disabled before disability income benefits may be payable. Your Benefit Waiting Period is shown in the Schedule of Benefits.]

### **[Co-Driver**

One of two drivers who take turns to drive a vehicle that is contracted to drive for the Participant. One of the drivers must be the insured Owner/Operator. All drivers must be legally licensed to drive the vehicle they are operating.]

### **[Contract Driver**

A driver who drives a power unit owned or leased by an Owner/Operator. A Contract Driver cannot be an employee of the Participant or the Owner/Operator.]

## **DEFINITIONS (Continued)**

### **[Covered Contract**

A long-term lease as defined by the U.S. Department of Transportation, Federal Motor Carrier Safety Administration. To be a "Covered Contract" such lease must meet all of the following:

- (1) It must be signed by both the Participant and the Owner/Operator.
- (2) The Owner/Operator must be responsible for:
  - (a) Power unit maintenance.
  - (b) Power unit operating costs, including but not limited to:
    - (i) Fuel.
    - (ii) Repairs
    - (iii) Physical damage insurance.
    - (iv) Personal expenses associated with the operation of the power unit.
- (3) The Owner/Operator must be compensated on a basis other than one based solely on time expended in performing work.
- (4) The Owner/Operator must have the responsibility for determining the time, means and method of performing the work.
- (5) The Owner/Operator must be an independent contractor. The Owner/Operator cannot be an employee of the Participant.

### **[Covered Person**

A person who is a member of an eligible class covered under this Policy as described in the Schedule of Benefits, for whom a request for insurance is received and appropriate premium has been paid when due and coverage is still in force.]

### **[Cumulative Trauma**

An injury diagnosed by a Physician as occurring without sudden cause or result. Cumulative Trauma includes injury caused by continual stress and strain. Such injury may be causally related to Your job. Such injury may be due to repetitive traumatic acts.]

### **[Health Care Plan**

Any plan providing medical expense benefits by:

- (1) any type of service plan contract, any group or blanket insurance, Independent Contractor benefit plan or any plan arranged through an employer, trustee, union or Independent Contractor benefit association;
- (2) Medicare or Medicaid; or
- (3) Any plan or program created or administered by the federal or state government or their agencies.]

### **[Home Health Care Agency**

An agency or organization that is either:

- (1) Approved under Medicare.
- (2) Established and operated in accordance with the applicable licensing and other laws.]

### **[Hospital**

An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and that fully meets one of the following tests:

- (1) It is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.
- (2) It is approved by Medicare as a hospital.]

**[DEFINITIONS  
(Continued**

**[Immediate Family**

Means You: wife or husband; In-laws; brother or sister; step-brother or step-sister; parent or step-parent; or child.]

**[Injury**

Means bodily harm which results, directly and independently of disease or bodily infirmity, from an Occupational Accident. All injuries to the same insured person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.]

**[Insured**

A member of an eligible class covered under this Policy as described in the Schedule of Benefits, for whom request for insurance is received and appropriate premium has been paid when due.]

**[Laborer**

An individual engaged by the Owner/Operator to handle manual tasks in regard to loading, unloading or otherwise assisting in the duties that the Owner/Operator has contracted to handle for the Participant. The laborer must not be an employee of the Participant and the Owner/Operator must submit the request for insurance on behalf of the laborer and the required premium must be paid. ]

**[Medical Emergency**

A condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.]

**[Medically Necessary**

We determine, in Our discretion, if a service or supply is medically necessary for the diagnosis and treatment of an Occupational Accidental injury. This determination is based on and consistent with standards approved by Our medical personnel. These standards are developed, in part, with consideration to whether the service or supply meets the following:

- (1) It is appropriate and required for the diagnosis or treatment of the Occupational Accidental injury
- (2) It is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- (3) There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the service or supply given.

A determination that a service or supply is not medically necessary may apply to the entire service or supply or to any part of the service or supply.]

**[Occupational Accident**

A sudden, unforeseen event, or series of events that are work related and that result in bodily injury within [72 hours] of the date of the event. This event must meet all of the following:

- (1) It must happen while You are Under Contract with the Participant and performing Your contract obligations under that contract.
- (2) It must happen while You are covered under this Plan.
- (3) The bodily injury must result directly from the Occupational Accident and not be the result of any other cause.

## **DEFINITIONS (Continued)**

"Occupational Accident" **does not** include any of the following:

- (1) Aggression in a fight.
- (2) Hernia of any type, unless specifically covered by this Plan.
- (3) Suicide or attempted suicide.
- (4) Cumulative Trauma, unless specifically covered by this Plan.
- (5) Occupational Disease, unless specifically covered by this Plan.]

### **[Occupational Disease**

A disease that:

- (1) Is not traceable to a specific Occupational Accident; and
- (2) Is caused by exposure to a disease producing agent present in Your occupational environment.]

### **[Other Income Benefits**

Other Income Benefits include any amounts that You or Your dependents receive (or are assumed to receive) under:

- (1) any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.
- (2) any Social Security or retirement benefits You receive or any third party receives (or is assumed to receive) on Your behalf or for Your dependents; or, if applicable, that Your dependents receive (or are assumed to receive) because of Your entitlement to such benefits.
- (3) Any proceeds payable under any group insurance or similar plan. If there is other insurance that applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, We will pay our pro rata share of the total claim.

"Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.]

### **[Other Services and Supplies**

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).]

### **[Owner/Operator**

A person who meets all of the following tests:

- (1) They are an Independent Contractor as defined by law.
- (2) They are not an employee of the Participant.
- (3) They have entered into a Covered Contract with the Participant for the leasing of the Owner/Operator's power unit.
- (4) They do not own or control the Participant.
- (5) They are compensated on a Form 1099 and not a Form W-2.

A Co-owner of a power unit will be considered an Owner/Operator as long as the Co-owner meets all of the above tests.]

### **[Participant**

Any entity or organization that has signed a Participation Agreement with the Policyholder and subscribes to the coverage provided by this Policy.]

## **DEFINITIONS (Continued)**

### **[Physician**

A licensed practitioner of the healing arts. The practitioner must be legally qualified to render the service being provided and not a member of the Covered Person's family or household.]

### **[Policy**

A legal contract between the Policyholder and Us, describing the terms and conditions of this coverage subject to any provisions, limitations, and exclusions.]

### **[Policyholder**

An entity to which We issue this Policy. The Policyholder is named on page 1.]

### **[Reasonable Charge**

An amount measured and determined by Us by comparing the actual charge for the service or supply with the prevailing charges made for it. We determine the prevailing charge. It takes into account all pertinent factors including:

- (1) The complexity of the service.
- (2) The range of services provided.
- (3) The prevailing charge levels in the geographic area where the provider is located and other geographic areas having similar medical cost experience.]

### **[Room and Board**

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.]

### **[Schedule of Benefits**

A section of the Certificate briefly outlining the coverage and benefits provided by the Policy.]

### **[Skilled Nursing Facility**

An institution that fully meets one of the following tests:

- (1) It is approved by Medicare as a Skilled Nursing Facility.
- (2) If not approved by Medicare, the facility must be operated under the applicable licensing and other laws of the jurisdiction where it is located.

It cannot be, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, or a home for alcoholics or drug addicts or the mentally ill.]

### **[Total Disability**

[For the first [26] [52] [104] [156] [208] weeks of Total Disability], Your inability to perform all of the substantial and material duties of Your regular employment or occupation [and earning less than 80% of your pre-disability earnings].

[For any period of Total Disability continuing for more than [26] [52] [104] [156] [208] weeks], You must meet both of the following:

- (1) You cannot be engaged in any work for pay or profit.
- (2) You must be unable to perform all the substantial and material duties of **any** occupation or employment that You are qualified for by reason of education, training or experience.]

**DEFINITIONS**  
**(Continued)**

**[Under Contract**

A Covered Owner/Operator while performing all the regular duties required by the Covered Contract with the Participating Organization. Under Contract also means for a covered member of an Eligible Class other than an Owner/Operator, performing the duties contracted with the Owner/Operator. . This includes traveling to and from the place of business and the location where these duties are performed, and where Your equipment receives routine scheduled maintenance.]

## UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3<sup>rd</sup> Floor • Eatontown, NJ 07724

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### DEPENDENT COVERAGE RIDER

**Effective Date:** \_\_\_\_\_

This Rider is made a part of the Policy and any Certificate to which it is attached. This Rider applies only to Accidents that occur on or after the Policy Effective Date shown in the Insured's Application or the Effective Date of this Rider, if later. This Rider is subject to all of the terms, limitations and exclusions of the Policy except as they are changed by this Rider.

Provided the Application is received and accepted by Us and the additional required premium is paid, We will provide the benefits described in this Rider.

#### **I. Dependents Coverage.** [(Not Applicable to Class 4 - Scheduled Laborers)]

##### **A. [Schedule of Benefits**

- 1 Your Dependent's Accident Medical/Dental Expense Benefits are payable [to the same extent these] [at [50%] of the] benefits [that] are payable for You.
- 2 Your Dependent's Principal Sum is shown on the Schedule of Benefits:
  - a. [For your covered Spouse:[50% of Your] Principal Sum]
  - b. [For your covered Dependent Child(ren): [20% of Your] Principal Sum]

##### **B. Eligibility:** Your Dependents are eligible on the date:

1. You are eligible, if You have a Dependent on that date; or
2. the date You acquire a Dependent, if later.

In no event will a Dependent be eligible if You are not insured for both Occupational Accident and Non-Occupational Accident Coverage under the Policy.

["Spouse" means Your lawful spouse or registered domestic partner, if required by law in your state, who is under age 65 and is not legally separated or divorced from You.]

["Dependent Child" means an Insured's or Insured's spouse's unmarried child to age 26. Insurance will continue for any Dependent child who reaches the age limit and is and continues to be both: (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to the attainment of 26 years of age, and (b) chiefly dependent upon the Insured or Insured's spouse for support and maintenance. The Insured or Insured's spouse must send Us satisfactory proof of the incapacity and dependency within 31 days of the child reaching the maximum age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. If the incapacity or dependency is later removed or terminated, You must notify Us of the change.]

[A Dependent child is automatically covered from the moment of birth until such child is 90 days old if all other eligible children are covered under the certificate prior to the birth of the child. The Insured must notify Us in writing within 90 days of such birth or before the next premium due date, whichever is later, and pay the required additional premium (if any), in order to have coverage for the child continue beyond such 90 day period. An adopted child is automatically covered for the first 60 days from the date of the Insured filing a petition for adoption unless the petition is denied or dismissed. The Insured must notify Us in writing within 60 days of filing the petition for adoption and pay the required additional premium (if any) in order to have coverage for the adopted child continue beyond such 60 day period.]

- C. Effective Date:** Insurance for Your Dependent who is named on Your Request for Insurance is effective on the latest of the following dates:
1. Your Effective Date;
  2. the date We receive the completed Request for Insurance for the Dependent, and the required premium for the Dependent is paid.
- D. [Deferred Effective Date:** If Your Dependent is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service. "Active Service" means Your Dependent, if employed, is performing all regular duties of his or her job on a full-time basis; or if not employed, is able to engage in substantially all of the usual activities of a person in of like age and gender and not confined in a Hospital or rehabilitation or rest facility. Your Dependent's insurance will not be in effect prior to Your effective date.]
- E. Termination Date Of Insurance:** Your Dependent's coverage will end on the earliest of the date:
1. Your coverage ends;
  2. the period ends for which premium is paid; or
  4. the date he or she is no longer a Dependent as defined herein.

## II. Benefits

- A.** [Benefits are payable for Accidental Death and Dismemberment and Accident Medical/Dental Expense Benefits as shown in the Schedule of Benefits.]
- B.** [The Principal Sum that applies to Your Dependent(s) is shown in the Schedule of Benefits.]
- C.** No Disability Income Benefits are payable for Your Dependent's Total Disability.
- D.** [Unless otherwise agreed to by Us, all benefits for Your Dependent's Loss of Life will be paid to You [in [monthly] installments.]

This rider ends at the same time as the Policy and Certificate. Nothing contained in this Rider will change, waive or extend any provision of the Policy except as stated herein.

SIGNED FOR THE UNITED STATES FIRE INSURANCE COMPANY BY:

Signature



Douglas M. Libby  
Chairman and CEO

Signature



James Kraus  
Secretary

**UNITED STATES FIRE INSURANCE COMPANY**  
Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

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**AMENDATORY ENDORSEMENT**  
(Applicable to **Arkansas** Residents Only)

This Amendatory Endorsement is attached to and made part of the Master Application, Certificate, Participation Agreement and Policy. It is subject to all of the provisions, limitations and exclusions of the Master Application, Certificate, Participation Agreement and Policy except as specifically modified by this Amendatory Endorsement.

1. The Policy is hereby modified to include following provision:

**Addition of New Persons [Dependents]:** All persons [or dependents] added to the Eligible Classes in the Schedule of Benefits are eligible for insurance under this Policy.

2. The face page of the Certificate is modified to include the following provision:

**[For Arkansas Residents: This Certificate is not a Workers' Compensation Contract and is not a substitute for Workers' Compensation Coverage and does not cover any person who is required to be covered by a Workers' Compensation Contract.]**

3. The "Assignment" provision under **CLAIMS INFORMATION** in the Certificate is hereby deleted in its entirety and replaced with the following language:

**Assignment**

This coverage may not be assigned. Benefit payments may be assigned at the time of claim. Any payment made by Us in good faith will end Our liability to the extent of the payment. We will deal with the assignee as the owner of the Policy in accordance with the terms of the assignment until We have received, at our home office, written notice of termination of the assignment, or written notice by or on behalf of some other person claiming some interest in the Policy in conflict with the assignment.

4. The "Time of Payment of Claims" provision under **CLAIMS INFORMATION** in the Certificate is hereby deleted in its entirety and replaced with the following language:

**Time of Payment of Claims**

Indemnities payable under the Policy for any loss other than loss for which this Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which We are liable. Any balance remaining unpaid upon the termination of that period of liability will be paid immediately upon receipt of due written proof.

5. The "Fraud Warning" on the Master Application is hereby deleted in its entirety and replaced with the following language:

**Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

6. The "Fraud Warning" on the Participation Agreement is hereby deleted in its entirety and replaced with the following language:

**Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.**

The President of **United States Fire Insurance Company** witnesses this Rider:

A handwritten signature in black ink that reads "Douglas M. Libby". The signature is written in a cursive style with a horizontal line at the end.

Douglas M. Libby  
**Chairman and CEO**