

SERFF Tracking Number: ZURC-126931924 State: Arkansas  
Filing Company: Zurich American Insurance Company State Tracking Number: 47465  
Company Tracking Number: CW AH 30149  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Blanket Accident Insurance Policy  
Project Name/Number: CW AH 30149 - Blanket Accident Insurance Policy/CW AH 30149

## Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Blanket Accident Insurance Policy SERFF Tr Num: ZURC-126931924 State: Arkansas

TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved-Closed State Tr Num: 47465

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: CW AH 30149 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Patricia Chudik Disposition Date: 12/16/2010

Date Submitted: 12/07/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: CW AH 30149 - Blanket Accident Insurance Policy

Project Number: CW AH 30149

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/16/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 11/15/2010

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Blanket, Other

Explanation for Other Group Market Type:

Schools/Educational Institutions statutorily eligible for Blanket Coverage

State Status Changed: 12/16/2010

Created By: Patricia Chudik

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Patricia Chudik

Filing Description:

This is a new Blanket Accident Insurance product, which will be marketed to statutorily eligible School/Educational Institution groups in your state consisting of two (2) or more individuals.

This Blanket Accident Insurance product may be marketed through brokers, consultants, third party administrators and sales employees.

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All forms are new and are not intended to replace any other forms currently in use.

The plan provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Coverage is offered on a contributory and non-contributory basis.

## Company and Contact

### Filing Contact Information

Patricia Chudik, Product Analyst pat.chudik@zurichna.com  
 1400 American Lane 847-605-7714 [Phone]  
 Schaumburg, IL 60196-1056 847-605-7768 [FAX]

### Filing Company Information

Zurich American Insurance Company CoCode: 16535 State of Domicile: New York  
 1400 American Lane Group Code: 212 Company Type:  
 Schaumburg, IL 60102 Group Name: State ID Number:  
 (847) 605-6000 ext. [Phone] FEIN Number: 36-4233459

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: Arkansas's fee is \$50 for a policy, applications and riders filing.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$50.00	12/07/2010	42697563
Zurich American Insurance Company	\$550.00	12/09/2010	42785415

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/16/2010	12/16/2010

### 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	12/09/2010	12/09/2010	Patricia Chudik	12/09/2010	12/09/2010

*SERFF Tracking Number:*      *ZURC-126931924*                      *State:*                      *Arkansas*  
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*Product Name:*              *Blanket Accident Insurance Policy*  
*Project Name/Number:*      *CW AH 30149 - Blanket Accident Insurance Policy/CW AH 30149*

## **Disposition**

Disposition Date: 12/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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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	Statement of variables for Arkansas	Approved-Closed	Yes
Supporting Document	Explanatory memorandum	Approved-Closed	Yes
Form	Blanket Accident Insurance Policy	Approved-Closed	Yes
Form	Application Blanket Accident Insurance	Approved-Closed	Yes
Form	Enrollment Form Blanket Accident Insurance	Approved-Closed	Yes
Form	Administrative Change Endorsement	Approved-Closed	Yes
Form	Accident Weekly Indemnity Benefit	Approved-Closed	Yes
Form	Catastrophe Cash Benefit	Approved-Closed	Yes
Form	Parent Reimbursement Benefit	Approved-Closed	Yes
Form	Policyholder Sponsored Activity Benefit	Approved-Closed	Yes
Form	Accident Excess Integrated Medical Expense Benefit	Approved-Closed	Yes
Form	Accident Excess Corridor Medical Expense Benefit	Approved-Closed	Yes
Form	Accident Medical Expense Benefit	Approved-Closed	Yes
Form	Heart Failure Benefit	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/09/2010

Submitted Date 12/09/2010

Respond By Date

Dear Patricia Chudik,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Blanket Accident Insurance Policy, U-BMC-100-A AR (07/10) (Form)
- Application Blanket Accident Insurance, U-BMC-101-A AR (07/10) (Form)
- Enrollment Form Blanket Accident Insurance, U-BMC-103-A AR (07/10) (Form)
- Administrative Change Endorsement, U-BMC-104-A CW (07/10) (Form)
- Accident Weekly Indemnity Benefit, U-BMC-117-A CW (07/10) (Form)
- Catastrophe Cash Benefit, U-BMC-125-A CW (07/10) (Form)
- Parent Reimbursement Benefit, U-BMC-133-A CW (07/10) (Form)
- Policyholder Sponsored Activity Benefit, U-BMC-135-A CW (07/10) (Form)
- Accident Excess Integrated Medical Expense Benefit, U-BMC-140-A CW (07/10) (Form)
- Accident Excess Corridor Medical Expense Benefit, U-BMC-141-A CW (07/10) (Form)
- Accident Medical Expense Benefit, U-BMC-142-A CW (07/10) (Form)
- Heart Failure Benefit, U-BMC-143-A CW (07/10) (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$600.00. Please submit an additional \$550.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

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 12/09/2010  
Submitted Date 12/09/2010

Dear Rosalind Minor,

### Comments:

Thank you for your correspondence regarding this filing.

### Response 1

Comments: I have submitted an additional \$550 through EFT.

### Related Objection 1

Applies To:

- Blanket Accident Insurance Policy, U-BMC-100-A AR (07/10) (Form)
- Application Blanket Accident Insurance, U-BMC-101-A AR (07/10) (Form)
- Enrollment Form Blanket Accident Insurance, U-BMC-103-A AR (07/10) (Form)
- Administrative Change Endorsement, U-BMC-104-A CW (07/10) (Form)
- Accident Weekly Indemnity Benefit, U-BMC-117-A CW (07/10) (Form)
- Catastrophe Cash Benefit, U-BMC-125-A CW (07/10) (Form)
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- Heart Failure Benefit, U-BMC-143-A CW (07/10) (Form)

Comment:

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**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please contact me if you have additional questions or concerns.

Sincerely,  
Patricia Chudik

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## Form Schedule

### Lead Form Number: U-BMC-100-A

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/16/2010 (07/10)	U-BMC-100-A AR	Policy/Cont	Blanket Accident ract/Fratern Insurance Policy al Certificate	Initial		54.000	U-BMC-100-A AR - Blanket Accident Insurance Policy for Schools.pdf
Approved-Closed 12/16/2010 (07/10)	U-BMC-101-A AR	Application/	Application Blanket Enrollment Accident Insurance Form	Initial		50.000	U-BMC-101-A AR - Application.pdf
Approved-Closed 12/16/2010 (07/10)	U-BMC-103-A AR	Application/	Enrollment Form Enrollment Blanket Accident Form Insurance	Initial		48.000	U-BMC-103-A AR - Enrollment Form.pdf
Approved-Closed 12/16/2010 (07/10)	U-BMC-104-A CW	Policy/Cont	Administrative ract/Fratern Change al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		48.000	U-BMC-104-A CW - Administrative Change Endorsement. pdf
Approved-Closed 12/16/2010 (07/10)	U-BMC-117-A CW	Policy/Cont	Accident Weekly ract/Fratern Indemnity Benefit al Certificate: Amendmen t, Insert Page, Endorseme	Initial		43.000	U-BMC-117-A CW - Accident Weekly Indemnity Benefit.pdf



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<i>Product Name:</i>	Blanket Accident Insurance Policy		
<i>Project Name/Number:</i>	CW AH 30149 - Blanket Accident Insurance Policy/CW AH 30149		
Closed 141-A CW	ract/Fratern Corridor Medical		CW - XS
12/16/2010 (07/10)	al Expense Benefit		Corridor
	Certificate:		Medical
	Amendmen		Expense
	t, Insert		Benefit.pdf
	Page,		
	Endorseme		
	nt or Rider		
Approved- U-BMC-	Policy/Cont Accident Medical	Initial	37.000
Closed 142-A CW	ract/Fratern Expense Benefit		U-BMC-142-A
12/16/2010 (07/10)	al		CW - Medical
	Certificate:		Expense
	Amendmen		Benefit.pdf
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- U-BMC-	Policy/Cont Heart Failure Benefit	Initial	58.000
Closed 143-A CW	ract/Fratern		U-BMC-143-A
12/16/2010 (07/10)	al		CW - Heart
	Certificate:		Failure
	Amendmen		Benefit.pdf
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		

# Blanket Accident Insurance Policy



**ZURICH AMERICAN INSURANCE COMPANY**

1400 American Lane  
Schaumburg, Illinois 60196

In return for the payment of premium expressed in the Schedule, **We** agree to pay the benefits of this **Policy** to the persons insured hereunder, subject to the terms and conditions which follow. **We** have issued this **Policy** to the **Policyholder**. This **Policy** is executed as of the Policy Inception Date shown in the Schedule which is its date of issue, and from which anniversary dates are measured.

**RENEWAL.** This **Policy** will automatically renew for an additional [twelve-month (12)] period unless either party expresses its intent not to renew as specified in the Termination of Insurance provisions shown in Section VII.A.

This **Policy** is delivered in, and subject to the laws of the Contract Situs in which it is issued.

**We** will pay benefits described in this **Policy** when an **Insured** suffers a **Covered Loss** as a result of participating in a **Covered Activity** described in the Schedule.

**[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]**

**THIS BLANKET ACCIDENT INSURANCE POLICY PROVIDES ACCIDENT COVERAGE ONLY  
THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS**

**We** and the **Policyholder** have agreed to all the terms of this **Policy**.

This is a legal contract between the **Policyholder** and **Us**.

IN WITNESS WHEREOF, this **Company** has executed and attested these presents and, where required by law, has caused this **Policy** to be countersigned by its duly Authorized Representative(s).

[ *Nancy D. Mueller*

President

*David J. Kennedy*  
Corporate Secretary]

**PLEASE READ THIS POLICY CAREFULLY**

**NON-PARTICIPATING**

TABLE OF CONTENTS

<u>SECTION</u>	<u>DESCRIPTION</u>
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Section III	DEFINITIONS
Section IV	GENERAL EXCLUSIONS
Section V	GENERAL LIMITATIONS
Section VI	PREMIUMS
Section VII	TERMINATION OF INSURANCE
Section VIII	HOW TO FILE A CLAIM
Section IX	PAYMENT OF CLAIMS
Section X	GENERAL POLICY CONDITIONS
Section XI	BENEFITS

SECTION I - SCHEDULE

- I. **POLICYHOLDER:** [John Doe Organization]  
 [123 Main Street]  
 [Anywhere, XX 10011]  
 [COVERED SUBSIDIARIES OR AFFILIATED COMPANIES: [ABC Company]]
- II. **POLICY NUMBER:** [ABC-1234567]
- III. **POLICY INCEPTION DATE:** [January 1, 2010]
- IV. **POLICY PERIOD:** [Effective Date] to [Expiration Date] [Continuous]  
 (All Insurance begins and ends at 12:01 a.m. at the **Policyholder's** address)
- V. **CONTRACT SITUS:** [ ]
- VI. **ELIGIBILITY AND CLASSIFICATION OF INSUREDS:**

The following individuals are eligible to become **Insureds** upon [completion of the **Service Waiting Period** as indicated below, and] the submission of completed enrollment material, if required:

- Class I: [All enrolled students of the **Policyholder**.]  
 [Class II: All enrolled participants of the **Policyholder**]  
 [Class III: All participants of the **Policyholder**]

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, and he or she is covered under more than one Class, **We** will pay only one benefit, the largest benefit.

**[SERVICE WAITING PERIOD:**

[[30 days] of **Active** continuous service.]]

VII. **COVERED ACTIVITY(IES):**

- Class I: [While participating in an assignment for the **Policyholder**, traveling directly to and from the assignment location and home, traveling on assignment for the **Policyholder**.]  
 [Class II: [While participating in **Policyholder** sponsored and supervised sporting events including practices, while traveling to and from the sponsored and supervised activity and while traveling, directly and without interruption, to and from any **Policyholder** sponsored activity.]]]

VIII. **[[AGGREGATE] LIMIT OF LIABILITY** [for air travel]: [\$5,000,000] per **Covered Accident]**

[If both **Non-Contributory** and **Contributory** benefits are included, the **[Aggregate] Limit of Liability** will only apply to the **Non-Contributory** benefits.]

IX. **BENEFITS:**

BENEFITS	CLASS COVERED	COVERAGE AMOUNT	FORM NUMBER
[Accidental Death Benefit]	[All]	[\$5,000]	[U-BMC-100- ]
[Accidental Dismemberment Benefit]	[All]	[\$5,000]	[U-BMC-100- ]
[Exposure and Disappearance Benefit]	[All]	[\$5,000]	[U-BMC-100- ]
[Accident Weekly Indemnity Benefit]	[All]	[[[\$400] per week for up to [52] weeks]	[U-BMC- ]
[Catastrophe Cash Benefit]	[All]	[Lump Sum: [\$50,000]] [Initial Lump Sum: [\$20,000]] [Monthly Amount: [\$10,000]] [Number of Months: [12]]	[U-BMC- ]
[Accident Medical Expense Benefit]	[All]	[See Benefit Rider]	[U-BMC- ]
[Accident Excess Integrated Medical Expense Benefit]	[All]	[See Benefit Rider]	[U-BMC- ]
[Accident Excess Corridor Medical Expense Benefit]	[All]	[See Benefit Rider]	[U-BMC- ]

[Heart Failure Benefit]	[All]	[\$5,000]	[U-BMC- ]
[Policyholder Sponsored Activity Benefit]	[All]	[The lesser of: (1) the remaining pro-rated cost, (2) [[3%] of the Accidental Death Benefit, or] (3) [\$3,000]]	[U-BMC- ]
[Parent Reimbursement Benefit]	[All]	[\$100] per week for a maximum of [12] months	[U-BMC- ]
[ ]	[ ]	[ ]	[U-BMC- ]

X. REPORTING AND NOTICE ADDRESSES:

Claim Reporting:

[Claims Department  
 Zurich American Insurance Company,  
 [P.O. Box 968041, Schaumburg, IL. 60196]]  
 [1-877-287-4805]

XI. PREMIUMS:

[Minimum and Deposit] Premium: [\$500.00] [per [year]] [subject to a [yearly] audit]

Premium Rate: [\$5.00] [per **Insured**] [per [year]]

Benefits under this **Policy** are [**Contributory**] [and] [**Non-Contributory**]. [The **Insured** is required to contribute [\$5.00] [per [year]].]

[The following is a summary of the **Contributory** benefits and the amount the **Insured** is required to contribute:

BENEFIT(S):

INSURED'S CONTRIBUTION

[Accidental Death Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Accidental Dismemberment Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Exposure and Disappearance Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Accident Weekly Indemnity Benefit]	[\$5.00] [per each additional [\$100] [per [year]]]
[Catastrophe Cash Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Accident Medical Expense Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Accident Excess Integrated Medical Expense Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Accident Excess Corridor Medical Expense Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Heart Failure Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Policyholder Sponsored Activity Benefit]	[\$5.00] [per each additional [\$1,000] [per [year]]]
[Parent Reimbursement Benefit]	[\$5.00] [per each additional [\$50] [per [year]]]
[ ]	[\$5.00] [per each additional [\$1,000] [per [year]]]

## SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

### INSURED'S EFFECTIVE DATE

An **Insured's** coverage under this **Policy** begins on the latest of:

1. the Policy Inception Date shown in the Schedule;
2. the date for which the first premium for the **Insured's** coverage is paid; or
3. the date the person becomes a member of an eligible class of persons as described in the ELIGIBILITY AND CLASSIFICATION OF INSUREDS section on the Schedule;

A change in an **Insured's** coverage under this **Policy** due to a change in his or her eligible class becomes effective on the later of:

1. when the change in his or her eligible class occurs; or
2. if the change requires a change in premium, the date the first changed premium is paid.

However, a change in coverage applies only with respect to **Accidents** that occur after the change becomes effective.

## SECTION III – DEFINITIONS

**Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

**Active** means [a member as defined by the **Policyholder** based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.].]

**[[Aggregate] Limit of Liability** means the total [Accidental Death Benefit] [,] [and] [Accidental Dismemberment Benefit] [,] [and] [Catastrophe Cash Benefit] [,] [and] [Exposure and Disappearance Benefit] [and] [Heart Failure Benefit], **We** will pay for a **Covered Accident** set forth in the Schedule. For purposes of the **[[Aggregate] Limit of Liability** provision, a **Covered Accident** will arise out of a single event and include a resulting **Covered Loss**. If the total benefits under the **[[Aggregate] Limit of Liability** is not enough to pay full benefits to each **Insured**, **We** will pay each one a reduced benefit based upon the proportion that the **[[Aggregate] Limit of Liability** bears to the total benefits which would otherwise be paid.]

**Contributory** means the **Insured** is required to pay all or a portion of the premium. Whether the benefits are **Contributory** or **Non-Contributory** is stated in the Schedule.

**Covered Accident** means an **Accident** that results in a **Covered Loss**.

**Covered Activity(ies)** means those activities set out in the COVERED ACTIVITIES section of the Schedule.

**Covered Injury** means bodily injury directly caused by **Accidental** means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Insured** is insured under this **Policy** and participating in a **Covered Activity**, and results in a **Covered Loss**.

**Covered Loss** means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**.

**Domestic Partner** means [a person who qualifies as a **Domestic Partner** under the **Policyholder's** written procedures as on file and approved by **Us**.] [a person who qualifies as a **Domestic Partner** under the law of the state of residence.] [as defined in the **Policyholder's** [medical] plan as on file and approved by **Us**.]

To qualify as a **Domestic Partner**, the following requirements must be met:

1. [the **Insured** and the **Domestic Partner** must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]
2. [the **Insured** and the **Domestic Partner** must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]
3. [the **Insured** and the **Domestic Partner** must both be at least 18 years of age;]
4. [neither the **Insured** nor the **Domestic Partner** are legally married;]
5. [the **Insured** and the **Domestic Partner** are not **Related** by blood or adoption;]
6. [the **Insured** and the **Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely;] [and]

7. [the **Insured** and the **Domestic Partner** must be of the same sex, and if applicable law permitted, would be married.]

The existence of the relationship between the **Domestic Partner** and the **Insured** must be evidenced by:

1. [the **Domestic Partner** being named as the primary beneficiary in the event of the **Insured's** death under the **Insured's** retirement plan or 401(k) plan, if the **Insured** maintains such a plan;]
2. [at least one of the following:
  - a. designation of the **Domestic Partner** as a primary beneficiary under the **Insured's** will; or
  - b. designation of the **Domestic Partner** as a primary beneficiary for the **Insured's** life insurance;]
3. [at least one of the following:
  - a. joint ownership of real estate (whether by mortgage, lease or deed);
  - b. joint ownership of a motor vehicle; or
  - c. joint ownership of a bank account; and]
4. [a completed, active certification of **Domestic Partner** status form on file with the **Policyholder**.]

To be active, the **Insured** will not have completed a Termination of **Domestic Partner** status form with respect to the **Domestic Partner**.]

**Foreign National** means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.]

**Insured** means any person who is eligible for coverage under this **Policy** as provided in the ELIGIBILITY AND CLASSIFICATION OF INSUREDS section of the Schedule, and who completes the enrollment material, if required.

**Limb** means an arm or a leg.

**Non-Contributory** means the **Insured** is not required to contribute toward the premium. Whether the benefits are **Contributory** or **Non-Contributory** is stated in the Schedule.

**Physician** means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that **We** recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not related to the **Insured** by blood or marriage.]

**Plan** means the coverages and/or benefits selected in the Schedule.]

**Policy** means this Blanket Accident Insurance Policy.

**Policyholder** means the entity named as such in the Schedule.

**Service Waiting Period** means the continuous length of time a person is required to be [employed][a member][a participant][by][of] the **Policyholder** prior to being covered under this **Policy**.]

**Spouse** means the **Insured's** legally married **Spouse**.

**We, Us, and Our** means Zurich American Insurance Company or **Our** authorized representative.

#### SECTION IV – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. [suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of auto-eroticism or auto-erotic asphyxiation].]
2. [war or any act of war, whether declared or undeclared.]
3. [involvement in any type of active military service. [For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.] [This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.]]

4. [illness or disease[, regardless of how contracted]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for **Accidental** ingestion of contaminated foods].]
5. [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [riot].]
6. [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity].]
7. [being intoxicated [while operating a motor vehicle].
  - a. An **Insured** will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle.
  - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the **Insured's** intoxication.]
8. [being under the influence of any prescription drug, controlled substance, or hallucinogen, unless such prescription drug, controlled substance, or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage.]
9. [travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight.]
10. [release[,whether or not **Accidental**, or by any person unlawfully or intentionally,] of nuclear energy or radiation, including sickness or disease resulting from such release.]
11. [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**.]
12. [alcoholism, drug addiction or the use of any drug or controlled substance except as prescribed by a licensed medical provider operating within his or her scope of authority.]
13. [participation in any team sport or any other athletic activity unless mentioned in the **Covered Activities**.]
14. [any condition for which the **Insured** is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.]
15. [the **Insured** riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.]
16. [any loss incurred while outside the United States, its territories or Canada.]

#### SECTION V – GENERAL LIMITATIONS

Benefits are payable only for **Covered Losses** incurred as a result of participation in **Covered Activities**.

[LIMITATION ON MULTIPLE COVERED LOSSES: If an **Insured** suffers more than one **Covered Loss** as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.]

[LIMITATION ON MULTIPLE COVERED ACTIVITIES: If an **Insured** suffers a **Covered Loss** while participating in more than one **Covered Activity**, **We** will pay only one benefit, the largest benefit [unless there is a specific written exception in this **Policy**.]

[LIMITATION ON MULTIPLE BENEFITS: If an **Insured** can recover benefits under more than one of the Benefits stated in the Schedule, as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.]

[LIMITATION ON MULTIPLE COVERED POLICIES: If an **Insured** can recover benefits under more than one accident policy written by Zurich American Insurance Company, **We** will pay under only one policy, the policy which offers the **Insured** the largest benefit.]

#### SECTION VI – PREMIUMS

A. **PREMIUMS:** Premiums are due and payable to **Us** at the rates and in the manner described in the Schedule. All rates are expressed and all premiums are payable in United States currency. If, at any time, it is determined that additional premium or a premium credit is due, the additional premium must be paid or the premium credit applied at the next premium due date. Except in the case of fraud, premium adjustments will be made only for the current Policy Period and the prior Policy Period.

B. **GRACE PERIOD:** Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If a renewal premium is not paid when it is due, there is a [thirty-one (31)] day Grace Period (the "Grace

Period") to pay. During the Grace Period, the **Policy** will stay in force. There will not be a Grace Period if **We** have given notice, at least [thirty (30)] days in advance, that **We** are going to terminate this **Policy**.

- C. **CHANGE IN PREMIUM:** **We** may change the premium as a condition of any renewal of this **Policy** by giving [at least [thirty-one (31)] days] written notice to the **Policyholder**. **We** may also change premium at any time when any change, agreed upon in writing, between the **Policyholder** and **Us** is made that affects coverage or if it is discovered that there was a material misrepresentation in the information relied upon in establishing the premiums.

#### SECTION VII - TERMINATION OF INSURANCE

A. **POLICY RENEWAL AND TERMINATION:**

**RENEWAL:** This **Policy** will automatically renew for an additional [twelve-month (12)] period unless either party expresses its intent to terminate as specified herein.

**TERMINATION BY POLICYHOLDER:** The **Policyholder** may terminate this **Policy** [on the first renewal date or at any time after that date] by delivering to **Us** a written notice to end this **Policy** at least [thirty (30)] days in advance of such termination. **We** will calculate and return the unearned premium, if any, using a standard short rate table. The **Policyholder** will send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

**TERMINATION BY US:** **We** may terminate this **Policy** [on any Policy Expiration Date] by giving the **Policyholder** at least [thirty (30)] days notice of **Our** intent to terminate. Such notice will state the exact date the **Policy** will terminate. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

**We** may also, at any time, end this **Policy** for non-payment of premium on any premium due date if the payment is not received prior to the end of the Grace Period. **We** will mail a notice of such termination to the **Policyholder's** last address shown in **Our** records.

Termination will be without prejudice to any claim which commenced prior to the effective date of termination.

#### SECTION VIII - HOW TO FILE A CLAIM

- A. **NOTICE:** The **Insured** or the beneficiary, or someone on their behalf, must give **Us** written notice of the **Covered Loss** within [ninety (90)] days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name the **Insured**, and the Policy Number. To request a claim form, the **Insured** or the beneficiary, or someone on their behalf may contact **Us** at [1-877-287-4805.] The notice must be sent to the address shown on the Schedule, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.
- B. **CLAIM FORMS:** **We** will send the claimant Proof of Covered Loss forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the Proof of Covered Loss form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the **Covered Loss**. **We** will accept this report as a Proof of Covered Loss if sent within the time fixed below for filing a Proof of Covered Loss.
- C. **PROOF OF COVERED LOSS:** Written Proof of Covered Loss, acceptable to **Us**, must be sent within [ninety (90)] days of the **Covered Loss**. Failure to furnish Proof of Covered Loss acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss, and the proof was provided as soon as reasonably possible.

#### SECTION IX - PAYMENT OF CLAIMS

- A. **TIME OF PAYMENT:** **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the Proof of Covered Loss that is acceptable to **Us**.
- B. **WHO WE WILL PAY:**
1. **LOSS OF LIFE OF AN INSURED:** **Covered Losses** resulting from the **Insured's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to [the beneficiary named by the **Insured** for the **Insured's** Life Insurance policy. If there is no beneficiary named by the **Insured** for the **Insured's** Life Insurance policy, or the named beneficiary predeceases or dies at the same time as the **Insured**, **We** will pay the benefit to] the **Insured's** estate.
  2. **ALL OTHER CLAIMS:** Benefits are to be paid to the **Insured**. [He or she may direct in writing that all, or part of the Accident [Excess] [Integrated] [Corridor] Medical Expense Benefit if applicable, will be paid directly to the

party who furnished the service. The direction may be changed by the **Insured** at any time up to the filing of the Proof of Covered Loss.]

3. [If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]
4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

#### SECTION X - GENERAL POLICY CONDITIONS

- A. **BENEFICIARIES:** The **Insured** has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. Unless an irrevocable beneficiary is named, The **Insured** may change the beneficiary at any time unless he or she has assigned the interest in the **Policy**. In such case, the person to whom he or she has assigned the interest in this **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed. Any beneficiary designation must be in writing on a form acceptable to **Us**.
- B. **CHANGE OR WAIVER:** A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.
- C. **CLERICAL ERROR:** A clerical error or omission will not increase or continue an **Insured's** coverage, which otherwise would not be in force. If an **Insured** applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.
- D. **CONFORMITY WITH STATUTE:** Terms of this **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.
- E. **ENTIRE CONTRACT:** This **Policy**, the **Policyholder** application, **Insured** enrollment materials, Benefit Riders, and any other attachments represent the entire insurance contract between the **Policyholder** and **Us**.
- F. **INSURED CERTIFICATES:** Where required by state law, **We** will make available certificates containing a summary of terms that affect benefits.
- G. **SUIT AGAINST US:** No action on this **Policy** may be brought until sixty (60) days after written Proof of Covered Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written Proof of Covered Loss was required to be submitted. If the law of the state where the **Insured** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.
- H. **PHYSICAL EXAMINATION AND AUTOPSY:** **We** have the right to examine an **Insured** when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** can have an autopsy performed unless forbidden by law.
- I. **POLICYHOLDER RECORDS:** The **Policyholder** will keep a record of the coverage, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.]
- J. **[REDUCTION SCHEDULE:** [At age [70], the [Accidental Death Benefit] [,] [and] [Accidental Dismemberment Benefit] [,] [and] [Catastrophe Cash Benefit] [,] [and] [Exposure and Disappearance Benefit] [and] [Heart Failure Benefit] will be reduced based on the **Insured's** previous benefit amount per the following schedule shown below for the attained age:

Age at Date of Loss	Percent of Original Benefit Amount
[Age 70-74]	[65%]
[Age 75-79]	[45%]
[Age 80-84]	[30%]
[Age 85 or over]	[15%]

These reductions also apply if coverage begins or coverage increases on or after the date of attaining age [70].]

- K. [CHOICE OF SERVICE PROVIDER: The **Insured** has the sole right to choose his or her duly licensed **Physician** and hospital.]
- L. [ARBITRATION: Any contest to a claim denial under this **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Insured**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured** is a resident of a state where the law does not allow binding arbitration in an insurance **Policy**, but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of a lawsuit by the **Insured**.]
- M. TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, statements made by the **Policyholder** or an **Insured** are deemed representations and not warranties. No such statement will cause **Us** to deny or reduce the benefits due under this **Policy** or be used as a defense of a claim, unless it is contained in a signed written application. After two years from the date coverage starts no such statement (except age) will cause this **Policy** to be contested.
- N. [COMMUTATION OF LOSSES: This **Policy** may be commuted through mutual agreement by the **Policyholder** and Zurich American Insurance Company. As of the commutation date both parties agree to release each other from any and all obligations to each other in connection with this **Policy** provided that the amount mutually agreed by both parties is paid at the time of commutation.]

SECTION XI – BENEFITS

[ACCIDENTAL DEATH BENEFIT

If an **Insured** suffers a loss of life as a result of a **Covered Injury**, **We** will pay the applicable amount shown in the Schedule. The death must occur within [365] days of the **Covered Injury**.]

[ACCIDENTAL DISMEMBERMENT BENEFIT

If a **Covered Injury** to an **Insured** results in any of the following **Covered Losses**, **We** will pay the percentage shown below. The **Covered Loss** must occur within [365] days of the **Covered Accident**.

The benefit amount is based on the maximum amount shown in the Schedule for the person suffering the **Covered Loss**.

<b>Covered Loss of</b>	Percentage of Maximum Amount
Both Hands or Both Feet	[100%]
One Hand and One Foot	[100%]
One Hand or One Foot plus the loss of Sight of One Eye	[100%]
Sight of Both Eyes	[100%]
Speech and Hearing	[100%]
Speech or Hearing	[50%]
One Hand; One Foot; or Sight of One Eye	[50%]
Thumb and Index Finger of the same Hand	[25%]
Hearing in One Ear	[25%]

[A reduced benefit will be payable equal to [50%] of the applicable Accidental Dismemberment Coverage for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the **Policy** are met. The balance of the applicable Accidental Dismemberment Coverage for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

For purposes of this Benefit, DEFINITIONS is amended to include the following:

**Covered Loss** means:

- 1. For a foot or hand, actual severance through or above the ankle or wrist joint;

2. For thumb and index finger, complete severance through or above the metacarpophalangeal joint of both digits;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.

**[Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [12] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible.

This benefit is payable based on the following table.

<b>COVERED LOSS OF USE OF</b>	<b>PERCENTAGE OF MAXIMUM AMOUNT</b>
Four <b>Limbs</b>	[100%]
Three <b>Limbs</b>	[75%]
Two <b>Limbs</b>	[66.67%]
One <b>Limb</b>	[50%]

**Covered Loss of Use** must [continue for [12] consecutive months and] be determined by **Our** competent medical authority.]

**[Plegia** means a permanent, complete and irreversible loss of voluntary movement that affects motor function of [one (1)] or more **Limbs**. Proof of total **Plegia** may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

This benefit is payable based on the following table.

<b>PLEGIA OF</b>	<b>PERCENTAGE OF MAXIMUM AMOUNT</b>
Quadriplegia (total paralysis of all four <b>Limbs</b> )	[100%]
[Triplegia (total paralysis of three <b>Limbs</b> )	[75%]]
Paraplegia (total paralysis of both lower <b>Limbs</b> )	[66.67%]
Hemiplegia (total paralysis of upper and lower <b>Limbs</b> on one side of the body)	[50%]
[Uniplegia (total paralysis of one <b>Limb</b> )	[25%]]

**Plegia** must [continue for [12] consecutive months and] be determined by **Our** competent medical authority.]

**[EXPOSURE AND DISAPPEARANCE BENEFIT**

If an **Insured** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable amount shown in the Schedule subject to all **Policy** terms.

If the conveyance in which an **Insured** is riding disappears, is wrecked, or sinks, and the **Insured** is not found within [365 days] of the event, **We** will presume that the person lost his or her life as a result of injury. If travel in such conveyance was covered under the terms of this **Policy**, **We** will pay the applicable amount shown in the Schedule, subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Insured** survived the event.]

**Application**  
**Blanket Accident Insurance**



**Zurich American Insurance Company**  
1400 American Lane  
Schaumburg, Illinois 60196

**APPLICANT INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Contact Title: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_ Contact Fax: \_\_\_\_\_  
Contact Email: \_\_\_\_\_  
Nature of Business: \_\_\_\_\_

**INSURANCE REQUESTED**

**A. ELIGIBILITY AND CLASSIFICATION OF INSURED**

Class Description

Class I: \_\_\_\_\_  
[Class II: \_\_\_\_\_  
[Class III: \_\_\_\_\_

**B. COVERED ACTIVITY(IES)**

Covered Activity

Class I: \_\_\_\_\_  
Class II: \_\_\_\_\_  
Class III: \_\_\_\_\_

**C. EXPOSURES**

Total Number of Participants: \_\_\_\_\_  
Number of Participants by Age: 12 and Under \_\_\_\_\_ 13 - 15 \_\_\_\_\_ 16 - 18 \_\_\_\_\_ 19 & Over \_\_\_\_\_  
Maximum Age: \_\_\_\_\_

**D. POLICY TERM**

Proposed Policy Effective Date: \_\_\_\_\_  
Proposed Policy Expiration Date: \_\_\_\_\_

**NOTICE OF DISCLOSURE FOR AGENT & BROKER COMPENSATION**

**If you want to learn more about the compensation Zurich pays agents and brokers visit:**

**<http://www.zurichnaproducercompensation.com>**

**or call the following toll-free number: (866) 903-1192.**

**This Notice is provided on behalf of Zurich American Insurance Company and its underwriting subsidiaries.**

**E. AGGREGATE LIMIT OF LIABILITY**

\$ \_\_\_\_\_ per **Covered Accident**

**F. BENEFITS**

Please indicate the benefit amount and limits requested:

Accidental Death Benefit Amount: \$ \_\_\_\_\_

Accidental Dismemberment Benefit Amount: \$ \_\_\_\_\_

Medical Expense Benefit:

Accident Medical Expense Amount: \$ \_\_\_\_\_

Deductible:  \$0.00  \$100 .00  \$250.00  \$500.00  Other \$ \_\_\_\_\_

[Accident Medical Expense Coverage:  Primary  Excess]

Accident Medical Expense Benefit Period:  52 weeks  104 weeks

Please list any other Benefits you request along with the Benefit Amounts

Benefit	Benefit Amount

**G. PREMIUM CONTRIBUTIONS**

Will participants contribute to the cost of their insurance under the proposed policy?  Yes  No

If yes, what percentage will the participant contribute? \_\_\_\_\_ %

**PRIOR COVERAGE**

Does this account presently have an in force Accident and Health Policy?  Yes  No

If yes, please provide the following information:

Insurance Company Name: \_\_\_\_\_

Current Effective Date: \_\_\_\_\_ Current Expiration Date: \_\_\_\_\_

Total Premium for the past 3 years: \_\_\_\_\_

Total Incurred on Claims for the past 3 years: \_\_\_\_\_

Total Number of Claims: \_\_\_\_\_

**PRODUCER INFORMATION**

Agent or Broker: \_\_\_\_\_

Name of Firm: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Contact Fax: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Producer Number: \_\_\_\_\_ Commission: \_\_\_\_\_

**NOTICES**

The **Company** and the **Insured Persons** declare that the statements set forth herein are true. The signing of this application does not bind the Underwriter, the **Policyholder** or its **Insured Persons** to effect insurance. The undersigned agrees that this application, its attachments and any materials submitted therewith are true, complete and accurate as of the date thereof. These representations shall be the basis of the contract should a policy be issued and shall be deemed attached to and shall form part of the policy. The application, its attachments and any materials submitted therewith are considered physically attached to the policy and will be deemed incorporated therein. The Underwriter is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

The undersigned, on behalf of the **Company** and all **Insured Persons**, agrees that if the information in the Declarations and representations contained in this application and its attachments materially changes between the date of this application and the inception of the proposed coverage, the undersigned will immediately report in writing to the Underwriter such change, and the Underwriter may withdraw or modify any outstanding quotations or agreements to bind coverage. The undersigned acknowledges and agrees that the Underwriter's receipt of such written report, prior to inception of the proposed coverage, is a condition precedent to coverage.

**FRAUD WARNING**

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

NAME OF APPLICANT: \_\_\_\_\_

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

# Enrollment Form

## Blanket Accident Insurance



Zurich American Insurance Company  
 1400 American Lane  
 Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of Policyholder:	[Master Policy Number:]

ENROLLEE INFORMATION			
Full Legal Name (First, Middle Initial and Last):		Last 4 Digits of SSN: XXX-XX-	
Street Address:	City:	State:	Zip Code:
Mailing Address (if different from above):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married [ <input type="checkbox"/> Domestic Partner]	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -
Requested Effective Date (MM/DD/YYYY):	[Certificate Number (assigned by the Company): ]		

PARENT OR LEGAL GUARDIAN INFORMATION (if Enrollee is a Minor)			
Full Legal Name (First, Middle Initial and Last):		Relationship to Enrollee: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	
Street Address (if different than Enrollee's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married [ <input type="checkbox"/> Domestic Partner]	
Email Address:	Home Phone: - -	Work Phone: - -	Cell Phone: - -

INSURANCE REQUESTED	
[Benefit(s) Included:	Coverage Amount
[Accidental Death Benefit]	[as per the Schedule]
[Accidental Dismemberment Benefit]	[as per the Schedule]
[Exposure and Disappearance Benefit]	[as per the Schedule]
[Accident Weekly Indemnity Benefit]	[as per the Schedule]
[Catastrophe Cash Benefit]	[as per the Schedule]
[Accident Medical Expense Benefit]	[as per the Schedule]
[Accident Excess Integrated Medical Expense Benefit]	[as per the Schedule]
[Accident Excess Corridor Medical Expense Benefit]	[as per the Schedule]
[Heart Failure Benefit]	[as per the Schedule]
[Policyholder Sponsored Activity Benefit]	[as per the Schedule]
[Parent Reimbursement Benefit]	[as per the Schedule]

[ ]	[as per the Schedule]]
<b>[Additional Coverage Amounts Requested</b> (please check all that apply):	<b>Coverage Amount</b> (please indicate amount):
<input type="checkbox"/> [Accidental Death Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accidental Dismemberment Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Exposure and Disappearance Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Weekly Indemnity Benefit]	[\$ ] [in increments of [\$100] not to exceed [\$400] per week]
<input type="checkbox"/> [Catastrophe Cash Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Medical Expense Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Excess Integrated Medical Expense Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Accident Excess Corridor Medical Expense Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Heart Failure Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Policyholder Sponsored Activity Benefit]	[\$ ] [in increments of [\$1,000] not to exceed [\$5,000]]
<input type="checkbox"/> [Parent Reimbursement Benefit]	[\$ ] [in increments of [\$50] not to exceed [\$100] per week]
<input type="checkbox"/> [ ]	[ ]

<b>BENEFICIARY DESIGNATION</b>		
<b>Primary Beneficiary:</b>		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:
<b>Contingent Beneficiary:</b>		
Full Legal Name (First, Middle Initial and Last):	Relationship:	% Share:

<b>PREMIUM INFORMATION:</b>	
Premium: \$	Frequency of Payment: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly
Method of Payment: <input type="checkbox"/> Credit Card <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/> Agency Bill The Enrollee, or if the Enrollee is a minor, the Enrollee's Parent or Legal Guardian, must complete a separate authorization form for a Credit Card or Bank Draft payment.	

**FRAUD WARNING**

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

The Enrollee hereby enrolls for Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich

American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

**It is hereby understood and agreed that:**

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the policy begins no sooner than the date the Company or its Agent approves the Enrollment Form.

Enrollee's Signature (may be electronic): \_\_\_\_\_

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

Parent or Legal Guardian's Signature (may be electronic): \_\_\_\_\_

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

<b>[AGENT INFORMATION</b>	
Name of Agent:	Agent's State License Number:
Agent's Signature:	[Producer Number:     ]]

# Administrative Change Endorsement



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This endorsement modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

[This endorsement will be used to make the following types of administrative changes to the **Policy**:

1. Policyholder's Name or Address;
2. Addition or deletion of subsidiaries or affiliates of the Policyholder;
3. Changes to the class(es) of eligible persons;
4. Addition or deletion of Benefit Riders; or
5. Increase or decrease in Benefit Amount(s).]

Except for the above, this endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of Policy No. \_\_\_\_\_

# Accident Weekly Indemnity Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If an **Insured** suffers a **Covered Injury**, which renders him or her **Totally Disabled**, **We** will pay an Accident Weekly Indemnity Benefit provided:

1. the **Total Disability** occurs within [thirty (30)] days of the date of the **Covered Injury**;
2. the **Insured** has satisfied the **Benefit Waiting Period** as shown in the Schedule; and
3. the **Insured** is being attended to by a duly licensed **Physician**.

Payments will begin on the first day after the **Benefit Waiting Period** and will continue for as long as the **Insured** is **Totally Disabled**, but will not exceed the **Benefit Period** of [fifty-two (52) weeks]. The amount of the payments will be equal to the amount shown on the Schedule.

For the purposes of this benefit only, DEFINITIONS is amended to include the following:

**Benefit Period** means the time period, after the end of the **Benefit Waiting Period**, that benefits are payable under this Benefit subject to any other restrictions or limitations in the **Policy**.

**Benefit Waiting Period** means [thirty (30)] consecutive days at the start of a period of continuous **Total Disability** for which **We** will not pay benefits.

**Total Disability (Totally Disabled)** means disability that: (1) prevents an **Insured** from performing the material and substantial duties of his or her occupation [or if for an **Insured** whom is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the insured] immediately prior to the **Accident** and (2) requires the **Continuous Care** and treatment of a **Physician**. If the **Insured** does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the **Insured** shall not qualify for this Benefit. The **Insured** shall not qualify for this Benefit if they engage in any activity which results in earned income.

**Continuous Care** means monthly monitoring and/or evaluation of the disabling condition by a **Physician**. **We** must receive proof of continuing **Total Disability** on a regular basis.

This Accident Weekly Indemnity benefit is subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Catastrophe Cash Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** within [365] days of a **Covered Accident** that results in **Paralysis, Coma or Brain Death, We** will pay a benefit as described below, provided that the **Paralysis, Coma or Brain Death**:

1. satisfies the **Benefit Waiting Period**;
2. must be determined by a **Physician** to be permanent and irreversible at the end of that **Benefit Waiting Period**; and
3. must result in **Disability**.

This benefit is payable based on the following table.

CAUSE OF DISABILITY	PERCENTAGE OF MAXIMUM AMOUNT(S)
Coma	[100%]
Paralysis of Two or More Limbs (Upper and/or Lower)	[100%]
Brain Death	[100%]
Paralysis of One Limb (Upper or Lower)	[50%]
Paralysis of One or More Other Parts of the Body	See below

NOTE: If the **Insured's Paralysis** is a part of the body other than a **Limb**, the percentage of the Maximum Amount used to determine the benefit payable will be adjusted in proportion to the comparable extent of **Paralysis** of the listed parts of the **Insured's** body.

If an **Insured** suffers more than one **Disability** as a result of the same **Accident**, only the largest PERCENTAGE OF MAXIMUM AMOUNT(S), will be used to determine the benefit payable.

The benefit payable is:

### [LUMP SUM:

The amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable after the **Benefit Waiting Period**]

### [MONTHLY

The monthly amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable in monthly installments after the **Benefit Waiting Period**. The benefit is payable monthly as long as an **Insured** remains continuously **Disabled** due to the **Paralysis, Coma or Brain Death**, but ceases on the earlie(r/st) of:

1. the date the **Insured** dies;
2. the date the **Insured** is no longer **Disabled** due to the **Paralysis, Coma or Brain Death**; or
3. the date monthly benefits have been paid for the maximum number of months shown on the Schedule for all **Disabilities** caused by the same **Accident**.]

### [INITIAL LUMP SUM THEN MONTHLY:

The initial lump sum amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable after the **Benefit Waiting Period**, followed by a monthly benefit stated in the Schedule,

starting one month after the end of the **Benefit Waiting Period**. The monthly benefit is payable monthly as long as an **Insured** remains continuously **Disabled** due to the **Paralysis, Coma** or **Brain Death**, but ceases on the earlie(r/st) of:

1. the date the **Insured** dies;
2. the date the **Insured** is no longer **Disabled** due to the **Paralysis, Coma** or **Brain Death**; or
3. the date monthly benefits have been paid for the maximum number of months shown in the Schedule for all **Disabilities** cause by the same **Accident**.]

If the **Insured** returns to any occupation for which he or she is qualified by reason of education, experience or training on a full or part-time basis, or engages in any of the usual activities of a person of like age and sex in comparable health, he or she may return to **Disability** status if:

1. the **Insured** has not been engaging in such activities for longer than [thirty (30)] days; and
2. the attending **Physician** certifies a return to **Disability** status due to the same **Paralysis, Coma** or **Brain Death** which caused the original **Disability**.

**We** reserve the right, at the end of the **Benefit Waiting Period** (and as often as it may reasonably require thereafter) to determine, on the basis of all the facts and circumstances, that the **Insured** is **Disabled** due to the **Paralysis, Coma** or **Brain Death**, including, but not limited to, requiring an independent medical examination at **Our** expense.

For the purposes of this benefit only, the following DEFINITIONS apply:

[**Benefit Waiting Period** means [six (6)] consecutive months at the start of a period of **Disability** for which **We** will not pay benefits.]

**Brain Death** means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain even though the heart is still beating.

**Coma** means a profound state of unconsciousness from which the **Insured** cannot be aroused to consciousness[, even by powerful stimulation], as determined by a **Physician**.

**Disabled/Disability** means that due to a **Covered Injury**, the **Insured** is unable while under the regular care of a **Physician** to perform the material and substantial duties of the occupation for which he or she is qualified by reason of education, experience or training. However, with respect to an **Insured** for whom an occupational definition of **Disabled/Disability** is not appropriate, **Disabled/Disability** means that the **Insured** is unable, while under the regular care of a **Physician**, to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the **Insured** immediately prior to the **Accident**. Periods of **Disability** separated by less than [thirty (30)] consecutive days will be considered one period of **Disability** resulting from the same **Covered Injury**, unless due to separate and unrelated causes.

**Paralysis** means the complete loss of function in a part of the body as a result of neurological damage, as determined by a **Physician**.

This Catastrophe Cash benefit is subject to the limitations in Section V General Limitations of the **Policy**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Parent Reimbursement Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

## THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If the **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, preventing the **Parent** from continuing to work in his or her normal wage paying occupation as a result of an unpaid leave of absence or quitting their job, **We** will pay an amount shown on the Schedule.

The **Parent** must show evidence that they took an unpaid leave of absence or quit their job based on a **Covered Injury** to the **Insured** to receive payment.

**We** reserve the right to determine, on the basis of all the facts and circumstances, that the **Insured** requires the ongoing attention of a **Parent** including, but not limited to, requiring an independent medical examination at **Our** expense.

For purposes of this benefit, **Parent** means the parent(s), grandparent(s) or legal guardian of the **Insured**[, or his or her **Spouse**] [or his or her **Domestic Partner**] who, at the time of a **Covered Accident**, is caring for the **Insured**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Policyholder Sponsored Activity Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

**THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If the **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** [as a result of a **Covered Accident**] [which is payable under the Accidental Death [or Accidental Dismemberment] Benefit], which at the direction of a **Physician** prevents the **Insured** from continuing to participate in a **Policyholder Sponsored Activity**, **We** will pay an additional benefit as shown on the Schedule.

For purposes of this benefit, **Policyholder Sponsored Activity** means that activity in which the **Insured** paid money to attend and is organized, administered, endorsed, or arranged by the **Policyholder**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Accident Excess Integrated Medical Expense Benefit



Zurich American Insurance Company  
 1400 American Lane  
 Schaumburg, Illinois 60196

**THIS RIDER CHANGES THE POLICY/CERTIFICATE. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

Benefit	Maximum Benefit per Insured per Covered Accident	Deductible per Insured per Covered Accident	[Our share of Usual and Customary expenses per Insured per Covered Accident]
Accident Medical	[\$10,000]	[\$100]	[80%]
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[80%]
[Pregnancy]	[\$1,000]	[\$100]	[80%]
[Custodial Services]	[\$1,000]	[\$100]	[80%]

We will pay [Our share of] the **Usual and Customary** expenses for **Medically Necessary Covered Medical Service(s)** incurred by the **Insured** resulting from a **Covered Accident** [while participating in a **Covered Activity**], up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:

1. the first treatment or service occurs within [ninety (90)] days of the **Covered Injury**; and
2. the medical expenses are incurred within [fifty-two (52)] weeks of the **Covered Injury**.

For this benefit only, the following definitions apply:

**Covered Medical Service(s)** means any of the following services:

1. **Hospital** room and board expenses: the daily room rate when an **Insured** is **Hospital Confined** and general nursing care is provided and charged for by the **Hospital**. In computing the expenses payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary **Hospital** expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **Hospital Confined**.
3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. **Physician** non-surgical treatment/examination expenses (excluding medicines) including the **Physician's** initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician.
7. **Physician's** surgical expenses: If a **Covered Injury** requires multiple surgical procedures during the same operative session through the same or different incision, **We** will pay only one benefit, the largest of the procedures performed.
8. Assistant physician expenses when **Medically Necessary**.
9. The services of a registered nurse when **Medically Necessary** (the nurse cannot be a member of the **Insured's** immediate family).

10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
  - a. is primarily and customarily used to serve a medical purpose;
  - b. can withstand repeated use; and
  - c. generally is not useful to a person in the absence of Injury.
 No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for an **Insured**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

**Custodial Services** means non-medical care, including, but not limited to, services:

1. related to watching or protecting the **Insured**;
2. related to performing, or assisting the **Insured** in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical personnel.

**Hospital** means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

**Hospital** does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

**Hospital Confined** means admission to a **Hospital** as an inpatient for at least [24] consecutive hours by a **Physician**. A **Hospital** stay that does not result in charges to the **Insured** is not a hospital confinement under this rider unless there is no charge because the **Hospital** is a United States government facility.

**In Force Policy** means any multiple group, group-type, family or individual health care policy covering the **Insured** and in effect at the time of the **Covered Injury**, or subsequently thereafter, other than the **Policy** to which this rider is attached.

**Medically Necessary** means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

**[Medical Repatriation** means transporting an **Insured** back to his or her principal residence or to the country where he or she was assigned. Such repatriation shall only result from the **Insured** being injured during a **Covered Activity**.]

**[Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6) months] immediately preceding the **Covered Loss**.]

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available]. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.

#### **EXCLUSIONS:**

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit for:

1. [Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.]
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. [Any expenses for a **Pre-existing Condition**.]
4. **Covered Injury** for which the **Insured** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.
5. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
6. Treatment by any immediate family member or member of the **Insured's** household.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
9. [A hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].
11. [A **Medical Repatriation**.]
12. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
13. Expenses which the **Insured** is not legally obligated to pay.
14. [Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.]

16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.]
17. [Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.]

#### **EXCESS INTEGRATED**

The benefit amount for this benefit is payable in excess of any **In Force Policy** and its applicable deductible. In the event and only in the event of the reduction or exhaustion of the limit of insurance of the **In Force Policy** solely as the result of actual payment of benefits covered thereunder, this **Policy** shall pay excess of the reduced limit of insurance of the **In Force Policy** and its applicable deductible. This **Policy** shall only pay pursuant to the terms and conditions of this **Policy** and no other policy.

**We** will pay the **Usual and Customary** amount, reduced by the payment by any other insurance plan. This **Policy** will recognize payment by any other insurance plan as reducing or satisfying the deductible amount of this **Policy**. In no event will **We** pay more than the maximum amount stated in this rider.

If no **In Force Policy** exists, this **Policy** will pay benefits on a primary basis [and a deductible [\$500] will apply to such benefit].

#### **[SUBROGATION**

**We** have the right to recover from any third party all payments including future payments, which **We** have made to the **Insured** or on behalf of the **Insured's Spouse** or **Domestic Partner**, child, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**, from any Third Party. If the **Insured** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Insured**. The **Insured** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_

# Accident Excess Corridor Medical Expense Benefit



Zurich American Insurance Company  
 1400 American Lane  
 Schaumburg, Illinois 60196

**THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

Benefit	Maximum Benefit per Insured per Covered Accident	Deductible per Insured per Covered Accident	[Our share of Usual and Customary expenses per Insured per Covered Accident]
Accident Medical	[\$10,000]	[\$100]	[80%]
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[80%]
[Pregnancy]	[\$1,000]	[\$100]	[80%]
[Custodial Services]	[\$1,000]	[\$100]	[80%]

We will pay [Our share of] the **Usual and Customary** expenses for **Medically Necessary Covered Medical Service(s)** incurred by the **Insured** resulting from a **Covered Accident** [while participating in a **Covered Activity**], up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:

1. the first treatment or service occurs within [ninety (90)] days of the **Covered Injury**; and
2. the medical expenses are incurred within [fifty-two (52)] weeks of the **Covered Injury**.

For this benefit only, the following definitions apply:

**Covered Medical Service(s)** means any of the following services:

1. **Hospital** room and board expenses: the daily room rate when an **Insured** is **Hospital Confined** and general nursing care is provided and charged for by the **Hospital**. In computing the expenses payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary **Hospital** expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **Hospital Confined**.
3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. **Physician** non-surgical treatment/examination expenses (excluding medicines) including the **Physician's** initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician.
7. **Physician's** surgical expenses: If a **Covered Injury** requires multiple surgical procedures during the same operative session through the same or different incision, **We** will pay only one benefit, the largest of the procedures performed.
8. Assistant physician expenses when **Medically Necessary**.
9. The services of a registered nurse when **Medically Necessary** (the nurse cannot be a member of the **Insured's** immediate family).

10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
  - a. is primarily and customarily used to serve a medical purpose;
  - b. can withstand repeated use; and
  - c. generally is not useful to a person in the absence of Injury.No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for an **Insured**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

**Custodial Services** means non-medical care, including, but not limited to, services:

1. related to watching or protecting the **Insured**;
2. related to performing, or assisting the **Insured** in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical personnel.

**Hospital** means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of **Physicians**; and
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

**Hospital** does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

**Hospital Confined** means admission to a **Hospital** as an inpatient for at least [24] consecutive hours by a **Physician**. A **Hospital** stay that does not result in charges to the **Insured** is not a hospital confinement under this rider unless there is no charge because the **Hospital** is a United States government facility.

**In Force Policy** means any multiple group, group-type, family or individual health care policy covering the **Insured** and in effect at the time of the **Covered Injury**, or subsequently thereafter, other than the **Policy** to which this rider is attached.

**Medically Necessary** means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

**[Medical Repatriation** means transporting an **Insured** back to his or her principal residence or to the country where he or she was assigned. Such repatriation shall only result from the **Insured** being injured during a **Covered Activity**.]

**[Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6) months] immediately preceding the **Covered Loss**.]

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available]. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.

#### **EXCLUSIONS:**

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit for:

1. [Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.]
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. [Any expenses for a **Pre-existing Condition**.]
4. **Covered Injury** for which the **Insured** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.
5. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
6. Treatment by any immediate family member or member of the **Insured's** household.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
9. [A hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].
11. [A **Medical Repatriation**.]
12. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
13. Expenses which the **Insured** is not legally obligated to pay.
14. [Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.]

16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.]
17. [Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.]

#### **EXCESS CORRIDOR**

The benefit amount for this benefit is payable in excess of any **In Force Policy** and its applicable deductible. In the event and only in the event of the reduction or exhaustion of the limit of insurance of the **In Force Policy** solely as the result of actual payment of benefits covered thereunder, this **Policy** shall pay excess of the reduced limit of insurance of the **In Force Policy** and its applicable deductible. This **Policy** shall only pay pursuant to the terms and conditions of this **Policy** and no other policy.

**We** will pay the **Usual and Customary** amount, reduced by any other insurance plan and the deductible amount, up to the maximum specified on the this rider. In no event will **We** pay more than the maximum amount stated in this rider.

If no **In Force Policy** exists, this **Policy** will pay benefits on a primary basis [and a deductible [\$500] will apply to such benefit].

#### **[SUBROGATION**

**We** have the right to recover from any third party all payments including future payments, which **We** have made to the **Insured** or on behalf of the **Insured's Spouse** or **Domestic Partner**, child, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**, from any Third Party. If the **Insured** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Insured**. The **Insured** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_

# Accident Medical Expense Benefit



Zurich American Insurance Company  
 1400 American Lane  
 Schaumburg, Illinois 60196

**THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

Benefit	Maximum Benefit per Insured per Covered Accident	Deductible per Insured per Covered Accident	[Our share of Usual and Customary expenses per Insured per Covered Accident]
Accident Medical	[\$10,000]	[\$100]	[80%]
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[80%]
[Pregnancy]	[\$1,000]	[\$100]	[80%]
[Custodial Services]	[\$1,000]	[\$100]	[80%]

We will pay [Our share of] the **Usual and Customary** expenses for **Medically Necessary Covered Medical Service(s)** incurred by the **Insured** resulting from a **Covered Accident** [while participating in a **Covered Activity**], up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible and subject to the co-insurance shown in the above Accident Medical Expense Schedule provided that:

1. the first treatment or service occurs within [ninety (90)] days of the **Covered Injury**; and
2. the medical expenses are incurred within [fifty-two (52)] weeks of the **Covered Injury**.

For this benefit only, the following definitions apply:

**Covered Medical Service(s)** means any of the following services:

1. **Hospital** room and board expenses: the daily room rate when an **Insured** is **Hospital Confined** and general nursing care is provided and charged for by the **Hospital**. In computing the expenses payable under this benefit, the date of admission will be counted but not the date of discharge.
2. Ancillary **Hospital** expenses: services and supplies including operating room, laboratory tests, anesthesia and medicines (excluding take home drugs) when **Hospital Confined**.
3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.
4. Outpatient surgical room and supply expenses for use of the surgical facility.
5. Outpatient diagnostic X-rays, laboratory procedures and tests.
6. **Physician** non-surgical treatment/examination expenses (excluding medicines) including the **Physician's** initial visit, each necessary follow-up visit and consultation visits when referred by the attending physician.
7. **Physician's** surgical expenses: If a **Covered Injury** requires multiple surgical procedures during the same operative session through the same or different incision, **We** will pay only one benefit, the largest of the procedures performed.
8. Assistant physician expenses when **Medically Necessary**.
9. The services of a registered nurse when **Medically Necessary** (the nurse cannot be a member of the **Insured's** immediate family).

10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
  - a. is primarily and customarily used to serve a medical purpose;
  - b. can withstand repeated use; and
  - c. generally is not useful to a person in the absence of injury.No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for an **Insured**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

**Custodial Services** means non-medical care, including, but not limited to, services:

1. related to watching or protecting the **Insured**;
2. related to performing, or assisting the **Insured** in performing any activities of daily living such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self-administered; and
3. that are not required to be performed by trained or skilled medical personnel.

**Hospital** means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of Physicians; and
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

**Hospital** does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home, or skilled nursing facility;
2. a place of rest, custodial care, or for the aged;
3. a clinic; or
4. a place for the treatment of mental illness, alcoholism or substance abuse.

However, a place for the treatment of mental illness, alcoholism or substance abuse will be regarded as a **Hospital** if it is:

1. part of the institution that meets the above requirements; and
2. listed in the American Hospital Association Guide as a general **Hospital**.

**Hospital Confined** means admission to a **Hospital** as an inpatient for at least [24] consecutive hours by a **Physician**. A **Hospital** stay that does not result in charges to the **Insured** is not a hospital confinement under this rider unless there is no charge because the **Hospital** is a United States government facility.

**Medically Necessary** means that the medical service or treatment:

1. is essential for the diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

**[Medical Repatriation** means transporting an **Insured** back to his or her principal residence or to the country where he or she was assigned. Such repatriation shall only result from the **Insured** being injured during a **Covered Activity**.]

**[Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6) months] immediately preceding the **Covered Loss**.]

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available]. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.

#### **EXCLUSIONS:**

In addition to the General Exclusions stated in the **Policy**, **We** will not cover expenses under this additional benefit for:

1. [Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.]
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. [Any expenses for a **Pre-existing Condition**.]
4. **Covered Injury** for which the **Insured** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or any statutory mandated coverage.
5. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
6. Treatment by any immediate family member or member of the **Insured's** household.
7. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.]
8. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
9. [A hernia.]
10. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].
11. [A **Medical Repatriation**.]
12. Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.
13. Expenses which the **Insured** is not legally obligated to pay.
14. [Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.]
15. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment of the underlying bodily condition.]
16. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.]

17. [Treatment for osteochondritis due to overuse and occurring during periods of rapid growth, including but not limited to Osgood-Schlatter Disease.]

**[SUBROGATION**

**We** have the right to recover from any third party all payments including future payments, which **We** have made to the **Insured** or on behalf of the **Insured's Spouse** or **Domestic Partner**, child, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**, from any Third Party. If the **Insured** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Insured**. The **Insured** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

# Heart Failure Benefit



Zurich American Insurance Company  
1400 American Lane  
Schaumburg, Illinois 60196

**THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

This rider modifies insurance provided under the Blanket Accident Insurance Policy.

It is hereby understood and agreed that the following changes are made and incorporated into the **Policy**:

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** as a result of a **Covered Accident**, which is a result of a **Heart Failure**, **We** will pay an additional amount shown in the Schedule. The **Heart Failure** must occur within [twenty-six (26) weeks] of the **Covered Accident**.

For the purposes of this benefit only, the following DEFINITION applies:

**Heart Failure** means death because the heart ceases to beat due to failure of the heart to maintain adequate circulation of blood provoked by participation in a **Covered Activity**.

Except for the above, this rider does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Effective Date: \_\_\_\_ Attached to and forming a part of **Policy** No. \_\_\_\_\_

SERFF Tracking Number: ZURC-126931924 State: Arkansas  
 Filing Company: Zurich American Insurance Company State Tracking Number: 47465  
 Company Tracking Number: CW AH 30149  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Blanket Accident Insurance Policy  
 Project Name/Number: CW AH 30149 - Blanket Accident Insurance Policy/CW AH 30149

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	12/16/2010
<b>Comments:</b>		
<b>Attachment:</b> U-BMC-100 Certificate of Readability for Arkansas.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	12/16/2010
<b>Bypass Reason:</b> Application and enrollment form are included. Please see forms schedule.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of variables for Arkansas	Approved-Closed	12/16/2010
<b>Comments:</b>		
<b>Attachment:</b> U-BMC-1000-A AR - Statement of Variables.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanatory memorandum	Approved-Closed	12/16/2010
<b>Comments:</b>		
<b>Attachment:</b> U-BMC-100 Explanatory Memorandum for Schools.pdf		

# Certificate of Readability for Arkansas



Zurich American Insurance Company

I have reviewed or supervised the preparation of the attached policy forms. I hereby certify that to the best of my knowledge, information, and belief, these policy forms comply with the minimum readability standards required by your State Insurance Code.

The policy forms listed below have achieved the following Flesch Scores using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-BMC-100-A (07/10)	Blanket Accident Insurance Policy	54
U-BMC-101-A (07/10)	Application	50
U-BMC-103-A (07/10)	Enrollment Form	48
U-BMC-104-A (07/10)	Administrative Change Endorsement	48
U-BMC-117-A (07/10)	Accident Weekly Indemnity Benefit	43
U-BMC-125-A (07/10)	Catastrophe Cash Benefit	49
U-BMC-133-A (07/10)	Parent Reimbursement Benefit	56
U-BMC-135-A (07/10)	Policyholder Sponsored Activity Benefit	40
U-BMC-140-A (07/10)	Accident Excess Integrated Medical Expense Benefit	38
U-BMC-141-A (07/10)	Accident Excess Corridor Medical Expense Benefit	38
U-BMC-142-A (07/10)	Accident Medical Expense Benefit	37
U-BMC-143-A (07/10)	Heart Failure Benefit	58

Although some of the forms listed above may not have achieved the minimum readability standards required by your State Insurance Code, we respectfully request approval based on our belief that:

1. the lower score provides a more accurate reflection of the readability of the form(s); and
2. the lower score is warranted by the nature of the particular form(s) or type or class of form(s).

Signature: 

Officer: Lisa Plante

Title: Head of A&H Product Management

Date: October 11, 2010



<p>[Class III: All participants]</p>	<p>members, the school and its students, or the vendor and its vendees, etc.</p> <p>If there is more than one Class eligible under the <b>Policy</b> a Schedule of Benefits may be presented for each Class if benefit applicability, amounts and duration differ by class or it may be presented in the aggregate.</p>
<p><b>[SERVICE WAITING PERIOD:</b></p> <p>[[30 days] of <b>Active</b> continuous service.]]</p>	<p>This provision will be in or out. If in</p> <p>The Service Waiting Period is variable and defined by the Policyholder</p> <p>[30 days] The range will be 1 – 120 days.</p>
<p>VII. Covered Activity(ies):</p> <p>Class I: [While participating in an assignment for the <b>Policyholder</b>, traveling directly to and from the assignment location and home, traveling on assignment for the <b>Policyholder</b>.]</p> <p>[Class II: [While participating in <b>Policyholder</b> sponsored and supervised sporting events including practices, while traveling to and from the sponsored and supervised activity and while traveling, directly and without interruption, to and from any <b>Policyholder</b> sponsored activity.]]</p>	<p>Covered Activity(ies) are variable and defined by the <b>Policyholder</b> based on elements relating to the relationship between the organization and its members, the school and its students or the vendor and its vendees, etc.</p>
<p>VIII. <b>[AGGREGATE] LIMIT OF LIABILITY</b> [for air travel]  [\$5,000,000] per <b>Covered Accident</b></p>	<p>This provision will be in or out. If in:</p> <p>[Aggregate] will be in or out;</p> <p>[for air travel] will be in or out;</p> <p>[\$5,000,000] The range will be \$1,000 - \$50,000,000;</p>
<p>IX. BENEFITS:</p> <p>[Accidental Death Benefit]  [\$5,000]</p> <p>[Accidental Dismemberment Benefit]  [\$5,000]</p> <p>[Accident Weekly Indemnity Benefit]  [[\$400] per week for up to [52] weeks]</p> <p>[Catastrophe Cash Benefit]  [Lump Sum: [\$50,000]]</p> <p>[Initial Lump Sum: [\$20,000]]</p> <p>[Monthly Amount: [\$10,000]]</p>	<p>IX. BENEFITS: each Benefit Rider listed will be in or out. If in, any Benefit Riders the <b>Policyholder</b> has selected will be included in the Schedule. The <b>Policyholder</b> will also decide which Class(es) are eligible for the Benefit Rider(s) and this too will be reflected in the Schedule. In addition, the Form Number(s) for the corresponding Benefit Rider(s) will be reflected in the Schedule.</p> <p>[\$5,000] The range will be \$500 - \$10,000,000</p> <p>[\$5,000] The range will be \$500 - \$10,000,000</p> <p>[\$400] The range will be \$100 - \$2,500  [52] The range will be 4 - 260</p> <p>[Lump Sum: [\$50,000]] will be in or out  [\$50,000] The range will be \$5,000 - \$5,000,000  [Initial Lump Sum: [\$20,000]] will be in or out  [\$20,000] The range will be \$5,000 - \$4,000,000  [Monthly Amount: [\$10,000]] will be in or out  [\$10,000] The range will be \$1,000 - \$100,000</p>



<p>[year]].]</p>	<p><b>[Non-Contributory]</b> will be in or out. [The <b>Insured</b> is required to contribute [\$5.00] [per [year]].] will be in or out. If in: [\$5.00] varies by calculation; [per [year]] will be in or out. If in; [year] will be either month, quarter, semi-annual or year.</p>				
<p>[The following is a summary of the <b>Contributory</b> benefits and the amount the <b>Insured</b> is required to contribute:</p>	<p>This entire section will be in or out. If in, each Benefit listed may be in or out. If a Benefit is in, the amount the Insured is required to contribute will be inserted.</p>				
<table border="0"> <tr> <td style="width: 25%;"><b>BENEFIT</b></td> <td style="width: 75%;"><b>INSURED'S CONTRIBUTION</b></td> </tr> <tr> <td>[Accidental Death]</td> <td>[\$5.00] [per each additional \$1,000] [per [year]]</td> </tr> </table>	<b>BENEFIT</b>	<b>INSURED'S CONTRIBUTION</b>	[Accidental Death]	[\$5.00] [per each additional \$1,000] [per [year]]	
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[Accidental Death]	[\$5.00] [per each additional \$1,000] [per [year]]				
<table border="0"> <tr> <td style="width: 25%;">[Accidental Dismemberment]</td> <td style="width: 75%;">[\$5.00] [per each additional \$1,000] [per [year]]</td> </tr> </table>	[Accidental Dismemberment]	[\$5.00] [per each additional \$1,000] [per [year]]			
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<table border="0"> <tr> <td style="width: 25%;">[Exposure and Disappearance]</td> <td style="width: 75%;">[\$5.00] [per each additional \$1,000] [per [year]]</td> </tr> </table>	[Exposure and Disappearance]	[\$5.00] [per each additional \$1,000] [per [year]]			
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[	[\$5.00] [per each additional \$1,000] [per [year]]]				

**SECTION III – DEFINITIONS**

<p><b>[Active]</b> means [a member as defined by the <b>Policyholder</b> based on elements relating to the relationship between the organization and its members, the school and its students, the creditor and its debtors, or the vendor and its vendees, etc.].]</p>	<p>This definition will be in or out. If in, <b>Active</b> will be defined by the <b>Policyholder</b>.</p>
<p><b>[[Aggregate] Limit of Liability</b> means the total [Accidental Death Benefit] [,] [and] [Accidental Dismemberment Benefit] [,] [and] [Catastrophe Cash Benefit] [,] [and] [Exposure and Disappearance Benefit] [,] [and] [Parent Reimbursement Benefit] [,] [and] [ Policyholder Sponsored Activity Benefit] [and] [Heart</p>	<p>This definition will be in or out. If in: [Aggregate] will be in or out;</p> <p>[Accidental Death Benefit] [,] [and] [Accidental Dismemberment Benefit] [,] [and] [Catastrophe Cash</p>

<p>Failure Benefit] <b>We</b> will pay for a <b>Covered Accident</b> or <b>Covered Accidents</b> set forth in the Schedule. For purposes of the <b>[Aggregate] Limit of Liability</b> provision, a <b>Covered Accident</b> will arise out of a single event and include a resulting <b>Covered Loss</b> or <b>Covered Losses</b>. If the total benefits under the <b>[Aggregate] Limit of Liability</b> is not enough to pay full benefits to each <b>Insured</b>, <b>We</b> will pay each one a reduced benefit based upon the proportion that the <b>[Aggregate] Limit of Liability</b> bears to the total benefits which would otherwise be paid.</p>	<p>Benefit] [,] [and] [Exposure and Disappearance Benefit] [,] [and] [Parent Reimbursement Benefit] [,] [and] [ Policyholder Sponsored Activity Benefit] [and] [Heart Failure Benefit] Each will be in or out</p>
<p><b>[Domestic Partner</b> means [a person who qualifies as a <b>Domestic Partner</b> under the <b>Policyholder's</b> written procedures as on file and approved by <b>Us</b>.] [a person who qualifies as a <b>Domestic Partner</b> under the law of the state of residence.] [as defined in the <b>Policyholder's</b> [medical] plan as on file and approved by <b>Us</b>.]</p> <p>To qualify as a <b>Domestic Partner</b>, the following requirements must be met:</p> <ol style="list-style-type: none"> <li>1. [the <b>Insured</b> and the <b>Domestic Partner</b> must have an intimate, committed relationship of mutual caring, and have agreed to be responsible for each other's welfare;]</li> <li>2. [the <b>Insured</b> and the <b>Domestic Partner</b> must have lived together in such a relationship for a period of not less than six consecutive months at the same residence address;]</li> <li>3. [the <b>Insured</b> and the <b>Domestic Partner</b> must both be at least 18 years of age;]</li> <li>4. [neither the <b>Insured</b> nor the <b>Domestic Partner</b> are legally married;]</li> <li>5. [the <b>Insured</b> and the <b>Domestic Partner</b> are not <b>Related</b> by blood or adoption;]</li> <li>6. [the <b>Insured</b> and the <b>Domestic Partner</b> are each other's sole <b>Domestic Partner</b> and intend to remain so indefinitely;] [and]</li> <li>7. [the <b>Insured</b> and the <b>Domestic Partner</b> must be of the same sex, and if applicable law permitted, would be married.]</li> </ol> <p>The existence of the relationship between the <b>Domestic Partner</b> and the <b>Insured</b> must be evidenced by:</p> <ol style="list-style-type: none"> <li>1. [the <b>Domestic Partner</b> being named as the primary beneficiary in the event of the <b>Insured's</b> death under the <b>Insured's</b> retirement plan or 401(k) plan, if the <b>Insured</b> maintains such a plan;]</li> <li>2. [at least one of the following: <ol style="list-style-type: none"> <li>a. designation of the <b>Domestic Partner</b> as a primary beneficiary under the <b>Insured's</b> will; or</li> <li>b. designation of the <b>Domestic Partner</b> as a primary beneficiary for the <b>Insured's</b> life insurance;]</li> </ol> </li> <li>3. [at least one of the following: <ol style="list-style-type: none"> <li>a. joint ownership of real estate (whether by mortgage, lease or deed);</li> <li>b. joint ownership of a motor vehicle; or</li> <li>c. joint ownership of a bank account; and]</li> </ol> </li> <li>4. [a completed, active certification of <b>Domestic Partner</b> status form on file with the <b>Policyholder</b>.]</li> </ol> <p>To be active, the <b>Insured</b> will not have completed a Termination of <b>Domestic Partner</b> status form with respect to the <b>Domestic Partner</b>.]</p>	<p>This definition and all bracketed portions of the definition will be in or out.</p>

<p><b>[Foreign National</b> means a person who is a citizen of a country or other jurisdiction other than the United States of America and who is not a resident of the United States of America.]</p>	<p>This definition will be in or out.</p>
<p><b>[Physician</b> means a person who is:</p> <ol style="list-style-type: none"> <li>1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that <b>We</b> recognize or are required by law to recognize;</li> <li>2. licensed to practice in the jurisdiction where care is being given;</li> <li>3. practicing within the scope of that license; and</li> <li>4. not related to the <b>Insured</b> by blood or marriage]</li> </ol>	<p>This definition will be in or out.</p>
<p><b>[Plan</b> means the coverages and/or benefits selected in the Schedule.]</p>	<p>This definition will be in or out.</p>
<p><b>[Service Waiting Period</b> means the continuous length of time a person is required to be [employed][a member][a participant][by][of] the <b>Policyholder</b> prior to being covered under this <b>Policy</b>.]</p>	<p>This will be in or out. If in, the <b>Service Waiting Period</b> is defined by the <b>Policyholder</b> based on elements relating to the relationship between the organization and its members, the school and its students, or the vendor and its vendees, etc.</p>

**SECTION IV – GENERAL EXCLUSIONS**

<p>1., 2., 3., 4., 5., 6., 7., 8., 9., 10., 11., 12., 13., 14., 15., 16.</p>	<p>Each exclusion will be in or out. If in:</p>
<p>1. [suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury [including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of auto-eroticism or auto-erotic asphyxiation].]</p>	<p>[including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of auto-eroticism or auto-erotic asphyxiation] will be in or out</p>
<p>3. [involvement in any type of active military service. [For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.][This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.]]</p>	<p>[For purposes of this exclusion, orders to active military service for [sixty (60) days] or less will not be considered involvement in active military service.] will be in or out, if in [sixty (60) days] The range will be 10 – 180</p> <p>[This exclusion does not apply to the first [sixty (60) consecutive days] of active military service.] will be in or out, if in, [sixty (60) days] The range will be 10 – 180</p>
<p>4. [illness or disease[, regardless of how contracted]; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; [except for <b>Accidental</b> ingestion of contaminated foods]</p>	<p>[, regardless of how contracted] will be in or out</p> <p>[except for <b>Accidental</b> ingestion of contaminated foods] will be in or out</p>
<p>5. [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] [or] [participation in a riot].]</p>	<p>[a crime,] will be in or out [any felony,] will be in or out [an assault,] will be in or out [insurrection] will be in or out [or] will be in or out [participation in a riot] will be in or out</p>
<p>6. [[parasailing,] [bungee jumping,] [heli-skiing,] [scuba diving] [or any other extra-hazardous activity].]</p>	<p>[parasailing,] will be in or out [bungee jumping,] will be in or out [heli-skiing,] will be in or out [scuba diving] will be in or out [or any other extra-hazardous activity] will be in or out</p>
<p>7. [being intoxicated [while operating a motor vehicle]. a. An <b>Insured</b> will be conclusively presumed to be in-</p>	<p>[while operating a motor vehicle] will be in or out</p>

<p>toxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the <b>Accident</b> occurred, to be intoxicated, if operating a motor vehicle.</p> <p>b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the <b>Insured's</b> intoxication.]</p>	
<p>10. [release[,whether or not <b>Accidental</b>, or by any person unlawfully or intentionally,] of nuclear energy or radiation, including sickness or disease resulting from such release.]</p>	<p>[,whether or not <b>Accidental</b>, or by any person unlawfully or intentionally,] will be in or out</p>

**SECTION V – GENERAL LIMITATION**

<p>[LIMITATION ON MULTIPLE COVERED LOSSES: If an <b>Insured</b> suffers more than one <b>Covered Loss</b> as a result of the same <b>Accident</b>, <b>We</b> will pay only one benefit, the largest benefit.]</p>	<p>This will be in or out</p>
<p>[LIMITATION ON MULTIPLE COVERED ACTIVITIES: If an <b>Insured</b> suffers a <b>Covered Loss</b> while participating in more than one <b>Covered Activity</b>, <b>We</b> will pay only one benefit, the largest benefit [unless there is a specific written exception in this <b>Policy</b>.]</p>	<p>This will be in or out [unless there is a specific written exception in this <b>Policy</b>] will be in or out</p>
<p>[LIMITATION ON MULTIPLE BENEFITS: If an <b>Insured</b> can recover benefits under more than one of the Benefits stated in the Schedule, as a result of the same <b>Accident</b>, <b>We</b> will pay only one benefit, the largest benefit.]</p>	<p>This will be in or out</p>
<p>[LIMITATION ON MULTIPLE COVERED POLICIES: If an <b>Insured</b> can recover benefits under more than one accident account written by Zurich American Insurance Company, <b>We</b> will pay under only one policy, the policy which offers the <b>Insured</b> the largest maximum.]</p>	<p>This will be in or out</p>

**SECTION VI – PREMIUMS**

<p>GRACE PERIOD: Premiums are due for this <b>Policy</b> on or before the premium due date or renewal date, whichever applies. If the <b>Policyholder</b> does not pay a renewal premium when it is due, there is a [thirty-one (31)] day Grace Period to pay. During the Grace Period, the <b>Policy</b> will stay in force. The <b>Policyholder</b> will not have a Grace Period if <b>We</b> have given notice, at least [thirty (30)] days in advance, that <b>We</b> are going to terminate this <b>Policy</b>.</p>	<p>[thirty-one (31)] The range will be 31 - 90</p> <p>[thirty (30)] The range will be 30 - 90</p>
<p>CHANGE IN PREMIUM: <b>We</b> may change the premium as a condition of any renewal of this <b>Policy</b> by giving [at least [thirty-one (31)] days] written notice to the <b>Policyholder</b>. <b>We</b> may also change premium at any time when any change, agreed upon in writing, between the <b>Policyholder</b> and <b>Us</b> is made that affects coverage or if it is discovered that there was a material misrepresentation in the information relied upon in establishing the premiums.</p>	<p>[at least [thirty-one (31)] days] This will be in or out. If in: [thirty-one (31)] The range will be 10 - 90</p>

**SECTION VII - TERMINATION OF INSURANCE**

<p>RENEWAL: This <b>Policy</b> will automatically renew for an additional [twelve-month (12)] period unless either party expresses its intent to terminate as specified herein.</p>	<p>[twelve-month (12)] The range will be 1-36</p>
<p>TERMINATION BY POLICYHOLDER: The <b>Policyholder</b> may terminate this <b>Policy</b> [on the first renewal date or at any time after that date] by delivering to <b>Us</b> a written notice to end this <b>Policy</b> at</p>	<p>[on the first renewal date or at any time after that date] will be in or out</p>

<p>least [thirty (30)] days in advance of such termination. <b>We</b> will calculate and return the unearned premium, if any, using a standard short rate table. The <b>Policyholder</b> will send <b>Us</b> any additional amounts owed, if any, between the <b>Policy's</b> paid to date and the official date of termination.</p>	<p>[thirty (30)] The range will be 10 – 90</p>
<p>TERMINATION BY US: <b>We</b> may terminate this <b>Policy</b> [on any Policy Expiration Date] by giving the <b>Policyholder</b> at least [thirty (30)] days notice of <b>Our</b> intent to terminate. Such notice will state the exact date the <b>Policy</b> will terminate. <b>We</b> will mail a notice of such termination to the <b>Policyholder's</b> last address shown in <b>Our</b> records.</p> <p><b>We</b> may also, at any time, end this <b>Policy</b> for non-payment of premium on any premium due date if the payment is not received prior to the end of the Grace Period. <b>We</b> will mail a notice of such termination to the <b>Policyholder's</b> last address shown in <b>Our</b> records.</p>	<p>[on any Policy Expiration Date] will be in or out [thirty (30)] The range will be 10 – 90</p>

### SECTION VIII - HOW TO FILE A CLAIM

<p>NOTICE: The <b>Insured</b> or the beneficiary, or someone on their behalf, must give <b>Us</b> written notice of the <b>Covered Loss</b> within [ninety (90)] days of such <b>Covered Loss</b>, or as soon thereafter as reasonably possible. The notice must name the <b>Insured</b>, and the Policy Number. To request a claim form, the <b>Insured</b> or the beneficiary, or someone on their behalf may contact <b>Us</b> at [1-877-287-4805.] The notice must be sent to the address shown on the Schedule, or any of <b>Our</b> agents. Notice to <b>Our</b> agents is considered notice to <b>Us</b>.</p>	<p>[ninety (90)] The range will be 20 - 120</p> <p>[1-877-287-4805.] This is variable in the event <b>Our</b> telephone number changes.</p>
<p>PROOF OF COVERED LOSS: Written Proof of Covered Loss, acceptable to <b>Us</b>, must be sent within [ninety (90)] days of the <b>Covered Loss</b>. Failure to furnish Proof of Covered Loss acceptable to <b>Us</b> within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the Proof of Covered Loss, and the proof was provided as soon as reasonably possible.</p>	<p>[ninety (90)] The range will be 90 - 180</p>

### SECTION IX - PAYMENT OF CLAIMS

<p>LOSS OF LIFE OF AN <b>INSURED</b>: <b>Covered Losses</b> resulting from the <b>Insured's</b> death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the <b>Insured</b>, <b>We</b> will pay the benefit to [the beneficiary named by the <b>Insured</b> for the <b>Insured's</b> Life Insurance policy. If there is no beneficiary named by the <b>Insured</b> for the <b>Insured's</b> Life Insurance policy, or the named beneficiary predeceases or dies at the same time as the <b>Insured</b>, <b>We</b> will pay the benefit to] the <b>Insured's</b> estate.</p>	<p>[the beneficiary named by the <b>Insured</b> for the <b>Insured's</b> Life Insurance policy. If there is no beneficiary named by the <b>Insured</b> for the <b>Insured's</b> Life Insurance policy, or the named beneficiary predeceases or dies at the same time as the <b>Insured</b>, <b>We</b> will pay the benefit to] will be in or out</p>
<p>ALL OTHER CLAIMS. Benefits are to be paid to the <b>Insured</b>. [He or she may direct in writing that all, or part of the Accident [Excess] [Integrated] [Corridor] Medical Expense Benefit if applicable, will be paid directly to the party who furnished the service. The direction may be changed by the <b>Insured</b> at any time up to the filing of the Proof of Covered Loss].</p>	<p>The last portion of this provision will be in or out. If in:  [Excess] will be in or out  [Integrated] will be in or out  [Corridor] will be in or out</p>

[If a **Foreign National** is entitled to benefits for a **Covered Loss** and **We** are unable to make payment directly to him or her because of legal restrictions in the country or jurisdiction where such **Foreign National** is located, **We** will either: (1) pay the benefits to a bank account owned by the **Foreign National** in the United States of America; or (2) if no such bank account is established or maintained, **We** will pay the benefits to the **Policyholder** on behalf of the **Foreign National**. It will then be the responsibility of the **Policyholder** to remit the benefit to such **Foreign National**. Payment of the benefit to the **Policyholder** will release **Us** from any further liability to the **Foreign National**. If the **Policyholder** does not remit the payment to the **Foreign National**, the **Policyholder** will indemnify **Us** and hold **Us** harmless against any and all liability incurred by **Us** including, but not limited to, interest, penalties, and attorneys' fees in connection with, arising or resulting from such failure to remit payment. The **Policyholder** will not be considered the beneficiary under the **Policy** if payment is made to the **Policyholder** in accordance with this provision.]

This provision will be in or out.

**SECTION X - GENERAL POLICY CONDITIONS**

**POLICYHOLDER RECORDS:** The **Policyholder** will keep a record of the coverage, premium and other pertinent administrative information for each **Insured**, which, if acceptable to **Us** will be deemed to be a part of the **Policy**. **We** may examine these records at reasonable times while the **Policy** is in force and for six years after the termination of the **Policy**. The **Policyholder** will report to **Us** within a reasonable time all changes in information regarding an **Insured**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function.]

The last portion of this provision will be in or out.

[REDUCTION SCHEDULE: [At age [70], the [Accidental Death Benefit] [,] [and] [Accidental Dismemberment Benefit] [,] [and] [Catastrophe Cash Benefit] [,] [and] [Exposure and Disappearance Benefit] [,] [and] [Policyholder Sponsored Activity Benefit] [,] [and] [Parent Reimbursement Benefit] [and] [Heart Failure Benefit] will be reduced based on the **Insured's** previous benefit amount per the following schedule shown below for the attained age:

Age at Date of Loss	Percent of Original Benefit Amount
[Age 70-74]	[65%]
[Age 75-79]	[45%]
[Age 80-84]	[30%]
[Age 85 or over]	[15%]

These reductions also apply if coverage begins or coverage increases on or after the date of attaining age [70].]

This provision will be in or out. If in:  
 [At age [70], will be in or out and the range will be 65 - 85.

[Accidental Death Benefit] [,] [and] [Accidental Dismemberment Benefit] [,] [and] [Catastrophe Cash Benefit] [,] [and] [Exposure and Disappearance Benefit] [,] [and] [Policyholder Sponsored Activity Benefit] [,] [and] [Parent Reimbursement Benefit] [and] [Heart Failure Benefit] Each will be in or out

[Age 70-74] the range will start at 65 – 74  
 [Age 70-74] the range will end at 74 - 80  
 [65%] the range will be 50% - 95%

[Age 75-79] the range will start at 75 – 79  
 [Age 75-79] the range will end at 79 - 85  
 [45%] the range will be 25% - 65%

[Age 80-84] the range will start at 80 - 84  
 [Age 80-84] the range will start at 84 - 90  
 [30%] the range will be 10% - 50%

[Age 85 or over] the range will start at 85 – 100  
 [15%] the range will be 5% - 25%

	[70] the range will be 65 - 85
[CHOICE OF SERVICE PROVIDER: The <b>Insured</b> has the sole right to choose his or her duly licensed <b>Physician</b> and hospital.]	This provision will be in or out.
[ARBITRATION: Any contest to a claim denial under this <b>Policy</b> will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the <b>Insured</b> . The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the <b>Insured</b> is a resident of a state where the law does not allow binding arbitration in an insurance <b>Policy</b> , but only if this <b>Policy</b> is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of lawsuit by the <b>Insured</b> .]	This provision will be in or out.
[COMMUTATION OF LOSSES: This <b>Policy</b> may be commuted through mutual agreement by the <b>Policyholder</b> and Zurich American Insurance Company. As of the commutation date both parties agree to release each other from any and all obligations to each other in connection with this <b>Policy</b> provided that the amount mutually agreed by both parties is paid at the time of commutation.]	This provision will be in or out.

## SECTION XI – BENEFITS

[ACCIDENTAL DEATH BENEFIT  If an <b>Insured</b> suffers a loss of life as a result of a <b>Covered Injury</b> , <b>We</b> will pay the applicable amount shown in the Schedule. The death must occur within [365] days of the <b>Covered Injury</b> .]	This Benefit will be in or out.  [365] The range will be 30 - 730.																				
[ACCIDENTAL DISMEMBERMENT BENEFIT  [If a <b>Covered Injury</b> to an <b>Insured</b> results in any of the following <b>Covered Losses</b> , <b>We</b> will pay the benefit amount shown below. The <b>Covered Loss</b> must occur within [365] days of the <b>Accident</b> .  <table border="0"> <thead> <tr> <th><b>Covered Loss</b> of</th> <th>Percentage of Maximum Amount</th> </tr> </thead> <tbody> <tr> <td>Both Hands or Both Feet</td> <td>[100%]</td> </tr> <tr> <td>One Hand and One Foot</td> <td>[100%]</td> </tr> <tr> <td>One Hand or One Foot plus the loss of Sight of One Eye</td> <td>[100%]</td> </tr> <tr> <td>Sight of Both Eyes</td> <td>[100%]</td> </tr> <tr> <td>Speech and Hearing</td> <td>[100%]</td> </tr> <tr> <td>Speech or Hearing</td> <td>[50%]</td> </tr> <tr> <td>One Hand; One Foot; or Sight of One Eye</td> <td>[50%]</td> </tr> <tr> <td>Thumb and Index Finger of the same Hand</td> <td>[25%]</td> </tr> <tr> <td>Hearing in One Ear</td> <td>[25%]</td> </tr> </tbody> </table> [A reduced benefit will be payable equal to [50%] of the applicable Accidental Dismemberment Coverage for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the <b>Policy</b> are met. The balance of the applicable Accidental Dismemberment	<b>Covered Loss</b> of	Percentage of Maximum Amount	Both Hands or Both Feet	[100%]	One Hand and One Foot	[100%]	One Hand or One Foot plus the loss of Sight of One Eye	[100%]	Sight of Both Eyes	[100%]	Speech and Hearing	[100%]	Speech or Hearing	[50%]	One Hand; One Foot; or Sight of One Eye	[50%]	Thumb and Index Finger of the same Hand	[25%]	Hearing in One Ear	[25%]	This Benefit will be in or out.  [365] The range will be 30 - 730;  Any combination of 1 - 9 may be in or out. If in: The range will be 50% - 200% The range will be 50% - 200%  The range will be 50% - 200% The range will be 50% - 200% The range will be 25% - 100%  The range will be 25% - 100%  The range will be 10% - 50% The range will be 10% - 50%  This section will be in or out, if in: [50%] The range will be 1% – 99%
<b>Covered Loss</b> of	Percentage of Maximum Amount																				
Both Hands or Both Feet	[100%]																				
One Hand and One Foot	[100%]																				
One Hand or One Foot plus the loss of Sight of One Eye	[100%]																				
Sight of Both Eyes	[100%]																				
Speech and Hearing	[100%]																				
Speech or Hearing	[50%]																				
One Hand; One Foot; or Sight of One Eye	[50%]																				
Thumb and Index Finger of the same Hand	[25%]																				
Hearing in One Ear	[25%]																				

Coverage for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that **Covered Loss of Use** then exists, provided all other provisions of the **Policy** are met.]

[**Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which [has continued for [12] consecutive months and] is determined by **Our** competent medical authority to be permanent, complete and irreversible.

[COVERED LOSS OF USE OF MAXIMUM	PERCENTAGE OF AMOUNT
Four <b>Limbs</b>	[100%]
Three <b>Limbs</b>	[75%]
Two <b>Limbs</b>	[66.67%]
One <b>Limbs</b>	[50%]

**Covered Loss of Use** must [continue for [12] consecutive months and] be determined by **Our** competent medical authority.]

[**Plegia** means a permanent, complete and irreversible loss of voluntary movement that affects motor function of [one (1)] or more **Limbs**. Proof of total **Plegia** may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.

<b>Plegia</b> of	Percentage of Maximum Amount
Quadriplegia (total paralysis of all four <b>Limbs</b> )	[100%]
[Triplegia (total paralysis of three <b>Limbs</b> )	[75%]
Paraplegia (total paralysis of both lower <b>Limbs</b> )	[66.67%]
Hemiplegia (total paralysis of upper and lower <b>Limbs</b> on one side of the body)	[50%]
[Uniplegia (total paralysis of one <b>Limb</b> )	[25%]

**Plegia** must [continue for [12] consecutive months and] be determined by **Our** competent medical authority.]

[365 days] The range will be 30 – 730

This section will be in or out, if in:  
[has continued for [12] consecutive months and] will be in or out. If in:  
[12] The range will be 3 - 24

This section will be in or out. If in:  
The range will be 50% - 200%  
The range will be 37.5% - 150%  
The range will be 33.33% - 133.33%  
The range will be 25% - 100%

[continue for [12] consecutive months and] will be in or out, if in;  
[12] The range will be 3 - 24

This section will be in or out, if in;  
[one (1)] The range will be 1 – 4

The range will be 50% - 200%  
This will be in or out. If in, the range will be 37.5% - 150%  
The range will be 33.33% - 133.33%  
The range will be 25% - 100%  
This will be in or out. If in, the range will be 12 1/2% - 50%

[continue for [12] consecutive months and] will be in or out, if in:  
[12] The range will be 3 – 24

**[EXPOSURE AND DISAPPEARANCE BENEFIT**

If an **Insured** is exposed to weather because of an **Accident** and this results in a **Covered Loss, We** will pay the applicable amount shown in the Schedule subject to all **Policy** terms.

If the conveyance in which an **Insured** is riding disappears, is wrecked, or sinks, and the **Insured** is not found within [365 days] of the event, **We** will presume that the person lost his or her life as a result of injury. If travel in such conveyance was covered under the terms of this **Policy, We** will pay the applicable amount shown in the Schedule subject to all **Policy** terms. **We** have the right to recover the benefit if **We** find that the **Insured** survived the event.]

This Benefit will be in or out. If in:

[365] The range will be 180 - 730

**APPLICATION – U-BMC-101-A AR (07/10)**

[Accident Medical Expense Coverage: <input type="checkbox"/> Primary <input type="checkbox"/> Excess]	This will be in or out.
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**ADMINISTRATIVE CHANGE ENDORSEMENT – U-BMC-104-A CW (07/10)**

<p>[This endorsement will be used to make the following types of administrative changes to the <b>Policy</b>:</p> <ol style="list-style-type: none"><li>1. Policyholder's Name or Address;</li><li>2. Addition or deletion of a subsidiary or affiliate of the Policyholder;</li><li>3. Changes to the class(es) of eligible persons;</li><li>4. Addition or deletion of Benefit Riders; or</li><li>5. Increase or decrease in Benefit Amount(s).]</li></ol>	<p>This endorsement will be used to make administrative changes to the Policy.</p>
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**ACCIDENT WEEKLY INDEMNITY BENEFIT – U-BMC-117-A CW (07/10)**

<p>The <b>Total Disability</b> occurs within [thirty (30)] days of the date of the <b>Covered Loss</b>;</p> <p>Payments will begin on the first day after the <b>Benefit Waiting Period</b> and will continue for as long as the Insured is <b>Totally Disabled</b>, but will not exceed the <b>Benefit Period</b> of [fifty-two (52) weeks]. The amount of the payments will be equal to the amount shown on the Schedule.</p> <p><b>Benefit Waiting Period</b> means [thirty (30)] consecutive days at the start of a period of continuous <b>Total Disability</b> for which <b>We</b> will not pay benefits.</p> <p><b>Total Disability (Totally Disabled)</b> means disability that: (1) prevents an <b>Insured</b> from performing the material and substantial duties of his or her occupation [or if for an <b>Insured</b> whom is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the <b>Insured</b>] immediately prior to the <b>Accident</b> and (2) requires the <b>Continuous Care</b> and treatment of a <b>Physician</b>. If the Insured does not adhere to the treatment plan the <b>Physician</b> prescribes relating to his or her disabling condition, the Insured shall not qualify for this Benefit. The <b>Insured</b> shall not qualify for this Benefit if they engage in any activity which results in earned income.</p>	<p>[thirty (30)] The range will be 15 - 365</p> <p>[fifty-two (52) weeks] The range will be 24 - 260</p> <p>[thirty (30)] The range will be 15 to 90</p> <p>[or if for an <b>Insured</b> whom is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the <b>Insured</b>] will be in or out</p>
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**CATASTROPHE CASH BENEFIT – U-BMC-125-A CW (07/10)**

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** within [365] days of a **Covered Accident** that results in **Paralysis, Coma** or **Brain Death**, We will pay a benefit as described below, provided that the **Paralysis, Coma** or **Brain Death**:

CAUSE OF DISABILITY	PERCENTAGE OF MAXIMUM AMOUNT
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<b>Coma</b>	[100%]
<b>Paralysis</b> of Two or More <b>Limbs</b> (Upper and/or Lower)	[100%]

<b>Brain Death</b>	[100%]
<b>Paralysis</b> of One or More <b>Limbs</b> (Upper and/or Lower)	[100%]

<b>Paralysis</b> of One or More Other Parts of the Body	[50%]
	See NOTE below

[LUMP SUM:  
The amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable after the **Benefit Waiting Period**]

[MONTHLY  
The monthly amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable in monthly installments after the **Benefit Waiting Period**. The benefit is payable monthly as long as an **Insured** remains continuously **Disabled** due to the **Paralysis, Coma** or **Brain Death**, but ceases on the earlie(r/st) of:

- (1) the date the **Insured** dies;
- (2) the date the **Insured** is no longer **Disabled** due to the **Paralysis, Coma** or **Brain Death** or
- (3) the date monthly benefits have been paid for the maximum number of months shown on the Schedule for all **Disabilities** caused by the same **Accident**.]

[INITIAL LUMP SUM THEN MONTHLY:  
The initial lump sum amount contained in the Schedule based on the PERCENTAGE OF MAXIMUM AMOUNT(S), payable after the **Benefit Waiting Period**, followed by a monthly benefit stated in the Schedule, starting one month after the end of the **Benefit Waiting Period**. The monthly benefit is payable monthly as long as an **Insured** remains continuously **Disabled** due to the **Paralysis, Coma** or **Brain Death**, but ceases on the earlie(r/st) of:

- (1) the date the **Insured** dies;
- (2) the date the **Insured** is no longer **Disabled** due to the **Paralysis, Coma** or **Brain Death** or
- (3) the date monthly benefits have been paid for the maximum number of months shown in the Schedule for all **Disabilities** cause by the same **Accident**.]

If the **Insured** returns to any occupation for which he or she is qualified by reason of education, experience or training on a

[365] The range will be 30 – 730

[100%] The range will be 50% - 200%

[100%] The range will be 50% - 200%

[100%] The range will be 50% - 200%

[50%] The range will be 25% - 100%

This section will be in or out

This section will be in or out, if in,

This section will be in or out, if in,

full or part-time basis, or engages in any of the usual activities of a person of like age and sex in comparable health, he or she may return to **Disability** status if:

- (1) the **Insured** has not been engaging in such activities for longer than [thirty (30)] days; and
- (2) the attending **Physician** certifies a return to **Disability** status due to the same **Paralysis, Coma** or **Brain Death** which caused the original **Disability**.

**[Benefit Waiting Period** means [six (6)] consecutive months at the start of a period of **Disability** for which **We** will not pay benefits.]

**Coma** means a profound state of unconsciousness from which the **Insured** cannot be aroused to consciousness[, even by powerful stimulation], as determined by a **Physician**.

**Disabled/Disability** means that due to a **Covered Injury**, the **Insured** is unable while under the regular care of a **Physician** to perform the material and substantial duties of the occupation for which he or she is qualified by reason of education, experience or training. However, with respect to an **Insured** for whom an occupational definition of **Disabled/Disability** is not appropriate, **Disabled/Disability** means that the **Insured** is unable, while under the regular care of a **Physician**, to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the **Insured** immediately prior to the **Accident**. Periods of **Disability** separated by less than [thirty (30)] consecutive days will be considered one period of **Disability** resulting from the same **Covered Injury**, unless due to separate and unrelated causes.

[thirty (30)] The range will be 15 - 365

If the Definition is in,  
[six (6)] The range will be 3 – 12

If the Definition is in,  
[, even by powerful stimulation] will be in or out

If the Definition is in,

[thirty (30)] The range will be 15 - 365

**PARENT REIMBURSEMENT BENEFIT – U-BMC-133-A CW (07/10)**

For purposes of this benefit, **Parent** means the parent(s), grand-parent(s) or legal guardian of the **Insured**, [or his or her **Spouse**] [or his or her **Domestic Partner**] who, at the time of a **Covered Accident**, is caring for the **Insured**.

[, or his or her **Spouse**] will be in or out  
[or his or her **Domestic Partner**] will be in or out

**POLICYHOLDER SPONSORED ACTIVITY BENEFIT – U-BMC-135-A CW (07/10)**

<p>If the <b>Insured</b> suffers a <b>Covered Injury</b> resulting in a <b>Covered Loss</b> [as a result of a <b>Covered Accident</b>] [which is payable under the Accidental Death [or Accidental Dismemberment] Benefit] , which prevents the <b>Insured</b> from continuing to participate in a <b>Policyholder Sponsored Activity</b> at the direction of a <b>Physician, We</b> will pay an additional benefit as shown on the Schedule.</p>	<p>This will be in or out. This will be in or out. If in: This will be in or out.</p>
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**ACCIDENT EXCESS INTEGRATED MEDICAL EXPENSE BENEFIT – U-BMC-140-A CW (07/10)**

Medical Expense Schedule				
Benefit	Maximum Benefit per <b>Insured</b> per <b>Covered Accident</b>	Deductible per <b>Insured</b> per <b>Covered Accident</b>	[Our share of <b>Usual and Customary</b> expenses per <b>Insured</b> per <b>Covered Accident</b>	[Our share of <b>Usual and Customary</b> expenses per <b>Insured</b> per <b>Covered Accident</b> ] will be in or out [Covered Accident] will be in or out [or] will be in or out
Accident Medical	[\$10,000]	[\$100]	[80%]	[\$10,000] The range will be \$500 - \$10,000,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Benefit Limitations:				The Benefit Limitations section will be in or out. If in:
[Accidental Dental]	[\$1,000]	[\$100]	[80%]	[Accidental Dental] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Pregnancy]	[\$1,000]	[\$100]	[80%]	[Pregnancy] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Custodial Services]	[\$1,000]	[\$100]	[80%]	[Custodial Services] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
<p><b>We will pay [Our share of] the Usual and Customary expenses for Medically Necessary Covered Medical Service(s) incurred by the Insured resulting from a Covered Accident [while participating in a Covered Activity], up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:</b></p> <ol style="list-style-type: none"> <li>the first treatment or service occurs within [ninety (90)] days of the <b>Covered Injury</b>; and</li> <li>the medical expenses are incurred within [fifty-two (52)] weeks of the <b>Covered Injury</b>.</li> </ol>				<p>[Our share of] will be in or out</p> <p>[while participating in a <b>Covered Activity</b>] will be in or out</p> <p>[ninety (90)] The range will be 30 – 1,825</p> <p>[fifty-two (52)] The range will be 24 – 520</p>
<p><b>Covered Medical Service(s)</b></p> <p>3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an <b>Accident</b> and including the attending <b>Physician's</b> charges, X-rays, laboratory procedures, use of the emergency room and supplies.</p> <p>12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.</p> <p>16. Ambulance expenses for transportation from the emergency site to the <b>Hospital</b> [(excluding air ambulance)].</p>				<p>[twenty-four (24)] The range will be 6 – 120</p> <p>[one (1)] The range will be 1 - 5 [twelve (12)] The range will be 3 – 15</p> <p>[(excluding air ambulance)] will be in or out</p>
<p><b>Hospital Confined</b> means admission to a <b>Hospital</b> as an inpatient for at least [24] consecutive hours by a <b>Physician</b>. A <b>Hospital</b> stay that does not result in charges to the <b>Insured</b> is not a hospital confinement</p>				<p>[24] The range will be 12 – 120</p>

under this rider unless there is no charge because the **Hospital** is a United States government facility.

**[Medical Repatriation** means transporting an **Insured** back to his or her principal residence or to the country where he or she was assigned. Such repatriation shall only result from the **Insured** being injured during a **Covered Activity**.]

**[Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6) months] immediately preceding the **Covered Loss**.]

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available]. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.

**Exclusions**

1., 3., 7., 9., 11., 14., 15., 16., 17.

11. Routine physical examinations and related medical services [,] [or] [elective treatment or surgery] [,] [or] [experimental or investigative treatments or procedures].

**[SUBROGATION**

**We** have the right to recover from any third party all payments including future payments, which **We** have made to the **Insured** or on behalf of the **Insured's Spouse** or **Domestic Partner**, child, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**, from any Third Party. If the **Insured** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Insured**. The **Insured** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

[This definition will be in or out

This definition will be in or out, if in:

[six (6) months] The range will be 3 months – 5 years

[or the fee set by the workers' compensation insurance fee schedule, if applicable] will be in or out

[and (3) does not exceed the cost of a generic drug, if available] will be in or out [seventy-five percent (75%)] The range will be 10% - 100%

Each Exclusion will be in or out

[,] will be in or out

[or] will be in or out

[elective treatment or surgery] will be in or out

[,] will be in or out

[or] will be in or out

[experimental or investigative treatments or procedures] will be in or out

This section will be in or out

**ACCIDENT EXCESS CORRIDOR MEDICAL EXPENSE BENEFIT – U-BMC-141-A CW (07/10)**

Medical Expense Schedule				
Benefit	Maximum Benefit per <b>Insured</b> per <b>Covered Accident</b>	Deductible per <b>Insured</b> per <b>Covered Accident</b>	[Our share of <b>Usual and Customary</b> expenses per <b>Insured</b> per <b>Covered Accident</b>	[Our share of <b>Usual and Customary</b> expenses per <b>Insured</b> per <b>Covered Accident</b> ] will be in or out [Covered Accident] will be in or out [or] will be in or out
Accident Medical	[\$10,000]	[\$100]	[80%]	[\$10,000] The range will be \$500 - \$10,000,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Benefit Limitations:				The Benefit Limitations section will be in or out. If in:
[Accidental Dental]	[\$1,000]	[\$100]	[80%]	[Accidental Dental] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Pregnancy]	[\$1,000]	[\$100]	[80%]	[Pregnancy] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Custodial Services]	[\$1,000]	[\$100]	[80%]	[Custodial Services] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
<p><b>We will pay [Our share of] the Usual and Customary expenses for Medically Necessary Covered Medical Service(s) incurred by the Insured resulting from a Covered Accident [while participating in a Covered Activity], up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:</b></p> <ol style="list-style-type: none"> <li>the first treatment or service occurs within [ninety (90)] days of the <b>Covered Injury</b>; and</li> <li>the medical expenses are incurred within [fifty-two (52)] weeks of the <b>Covered Injury</b>.</li> </ol>				<p>[Our share of] will be in or out</p> <p>[while participating in a <b>Covered Activity</b>] will be in or out</p> <p>[ninety (90)] The range will be 30 – 1,825</p> <p>[fifty-two (52)] The range will be 24 – 520</p>
<p><b>Covered Medical Service(s)</b></p> <p>3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an <b>Accident</b> and including the attending <b>Physician's</b> charges, X-rays, laboratory procedures, use of the emergency room and supplies.</p> <p>12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.</p> <p>16. Ambulance expenses for transportation from the emergency site to the <b>Hospital</b> [(excluding air ambulance)].</p>				<p>[twenty-four (24)] The range will be 6 – 120</p> <p>[one (1)] The range will be 1 - 5 [twelve (12)] The range will be 3 – 15</p> <p>[(excluding air ambulance)] will be in or out</p>
<p><b>Hospital Confined</b> means admission to a <b>Hospital</b> as an inpatient for at least [24] consecutive hours by a <b>Physician</b>. A <b>Hospital</b> stay that does not result in charges to the <b>Insured</b> is not a hospital confinement</p>				<p>[24] The range will be 12 – 120</p>

under this rider unless there is no charge because the **Hospital** is a United States government facility.

**[Medical Repatriation** means transporting an **Insured** back to his or her principal residence or to the country where he or she was assigned. Such repatriation shall only result from the **Insured** being injured during a **Covered Activity**.]

**[Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6) months] immediately preceding the **Covered Loss**.]

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available]. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.

**Exclusions**

1., 3., 7., 9., 11., 14., 15., 16., 17.

11. Routine physical examinations and related medical services [,] [or] [elective treatment or surgery] [,] [or] [experimental or investigative treatments or procedures].

**[SUBROGATION**

**We** have the right to recover from any third party all payments including future payments, which **We** have made to the **Insured** or on behalf of the **Insured's Spouse** or **Domestic Partner**, child, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**, from any Third Party. If the **Insured** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Insured**. The **Insured** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

This definition will be in or out

This definition will be in or out, if in:

[six (6) months] The range will be 3 months – 5 years

[or the fee set by the workers' compensation insurance fee schedule, if applicable] will be in or out  
[and (3) does not exceed the cost of a generic drug, if available] will be in or out  
[seventy-five percent (75%)] The range will be 10% - 100%

Each Exclusion will be in or out

[,] will be in or out  
[or] will be in or out  
[elective treatment or surgery] will be in or out  
[,] will be in or out  
[or] will be in or out  
[experimental or investigative treatments or procedures] will be in or out

This section will be in or out

**ACCIDENT MEDICAL EXPENSE BENEFIT – U-BMC-142-A CW (07/10)**

Medical Expense Schedule				
Benefit	Maximum Benefit per <b>Insured</b> per <b>Covered Accident</b>	Deductible per <b>Insured</b> per <b>Covered Accident</b>	[Our share of <b>Usual and Customary</b> expenses per <b>Insured</b> per <b>Covered Accident</b>	[Our share of <b>Usual and Customary</b> expenses per <b>Insured</b> per <b>Covered Accident</b> ] will be in or out
Accident Medical	[\$10,000]	[\$100]	[80%]	[\$10,000] The range will be \$500 - \$10,000,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Benefit Limitations:				The Benefit Limitations section will be in or out. If in:
[Accidental Dental]	[\$1,000]	[\$100]	[80%]	[Accidental Dental] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Pregnancy]	[\$1,000]	[\$100]	[80%]	[Pregnancy] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
[Custodial Services]	[\$1,000]	[\$100]	[80%]	[Custodial Services] will be in or out, if in, [\$1,000] The range will be \$500 - \$5,000 [\$100] The range will be \$25 - \$100,000 [80%] The range will be 50% - 100%
<p><b>We will pay [Our share of] the Usual and Customary expenses for Medically Necessary Covered Medical Service(s) incurred by the Insured resulting from a Covered Accident [while participating in a Covered Activity], up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:</b></p> <ol style="list-style-type: none"> <li>the first treatment or service occurs within [ninety (90)] days of the <b>Covered Injury</b>; and</li> <li>the medical expenses are incurred within [fifty-two (52)] weeks of the <b>Covered Injury</b>.</li> </ol>				<p>[Our share of] will be in or out</p> <p>[while participating in a <b>Covered Activity</b>] will be in or out</p> <p>[ninety (90)] The range will be 30 – 1,095</p> <p>[fifty-two (52)] The range will be 24 – 520</p>
<p><b>Covered Medical Service(s)</b></p> <p>3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an <b>Accident</b> and including the attending <b>Physician's</b> charges, X-rays, laboratory procedures, use of the emergency room and supplies.</p> <p>12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.</p> <p>16. Ambulance expenses for transportation from the emergency site to the <b>Hospital</b> [(excluding air ambulance)].</p>				<p>[twenty-four (24)] The range will be 6 – 120</p> <p>[one (1)] The range will be 1 - 5 [twelve (12)] The range will be 3 – 15</p> <p>[(excluding air ambulance)] will be in or out</p>
<p><b>Hospital Confined</b> means admission to a <b>Hospital</b> as an inpatient for at least [24] consecutive hours by a <b>Physician</b>. A <b>Hospital</b> stay that does not result in charges to the <b>Insured</b> is not a hospital confinement</p>				<p>[24] The range will be 12 – 120</p>

under this rider unless there is no charge because the **Hospital** is a United States government facility.

**[Medical Repatriation** means transporting an **Insured** back to his or her principal residence or to the country where he or she was assigned. Such repatriation shall only result from the **Insured** being injured during a **Covered Activity**.]

**[Pre-existing Condition** means a condition for which an **Insured** received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6) months] immediately preceding the **Covered Loss**.]

**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available]. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.

**Exclusions**

1., 3., 7., 9., 11., 14., 15., 16., 17.

11. Routine physical examinations and related medical services [,] [or] [elective treatment or surgery] [,] [or] [experimental or investigative treatments or procedures].

**[SUBROGATION**

**We** have the right to recover from any third party all payments including future payments, which **We** have made to the **Insured** or on behalf of the **Insured's Spouse** or **Domestic Partner**, child, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**, from any Third Party. If the **Insured** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the **Insured**. The **Insured** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

This definition will be in or out

This definition will be in or out, if in

[six (6) months] The range will be 3 months – 5 years

[or the fee set by the workers' compensation insurance fee schedule, if applicable] will be in or out

[and (3) does not exceed the cost of a generic drug, if available] will be in or out [seventy-five percent (75%)] The range will be 10% - 100%

Each Exclusion will be in or out

[,] will be in or out

[or] will be in or out

[elective treatment or surgery] will be in or out

[,] will be in or out

[or] will be in or out

[experimental or investigative treatments or procedures] will be in or out

This section will be in or out

**HEART FAILURE BENEFIT – U-BMC-143-A CW (07/10)**

If an **Insured** suffers a **Covered Injury** resulting in a **Covered Loss** as a result of a **Covered Accident**, which is a result of a **Heart Failure**, **We** will pay an additional amount shown in the Schedule. The **Heart Failure** must occur within [twenty-six (26) weeks] of the **Covered Accident**.

[twenty-six (26) weeks] The range will be 4 – 52 weeks



**Zurich American Insurance Company**

**EXPLANATORY MEMORANDUM  
Blanket Accident Insurance Policy for Schools  
Company Filing Number – 30149  
U-BMC-100-A (07/10), et al**

This is a new Blanket Accident Insurance product, which will be marketed to statutorily eligible School/Educational Institution groups in your state consisting of two (2) or more individuals.

This Blanket Accident Insurance product may be marketed through brokers, consultants, third party administrators and sales employees.

All forms are new and are not intended to replace any other forms currently in use.

The plan provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

Coverage is offered on a contributory and non-contributory basis.

Variable data is bracketed. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort has been made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

This filing includes a certification of readability and statement of variables.