

SERFF Tracking Number: ZURC-126395461 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 44259
Company Tracking Number: CW AH 29319
TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
Product Name: Accident Insurance Policy
Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Accident Insurance Policy SERFF Tr Num: ZURC-126395461 State: Arkansas
TOI: H03I Individual Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved- Closed State Tr Num: 44259
Sub-TOI: H03I.000 Health - Accidental Death & Co Tr Num: CW AH 29319 State Status: Approved-Closed
Dismemberment
Filing Type: Form/Rate Reviewer(s): Rosalind Minor
Authors: Patricia Chudik, Karen Falbo Disposition Date: 02/10/2010
Date Submitted: 12/07/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: CW AH 29319 - Accident Insurance Policy
Project Number: CW AH 29319
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 02/10/2010

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 10/14/2009
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 02/10/2010
Created By: Patricia Chudik
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Patricia Chudik

Filing Description:

This is a new Individual Accident Insurance product, which will be marketed to individuals in your state.

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

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

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The plan provides specified benefits for an accidental injury or death. 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: \$100.00
 Retaliatory? No
 Fee Explanation: Arkansas's fee is \$50 for forms and \$50 for rates.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$100.00	12/07/2009	32515734

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/10/2010	02/10/2010

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	12/08/2009	12/08/2009	Patricia Chudik	02/09/2010	02/09/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection letter of 12/8/09	Note To Filer	Rosalind Minor	01/26/2010	01/26/2010

SERFF Tracking Number: ZURC-126395461 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document (revised)	Explanatory memorandum and statement of variables	Approved-Closed	No
Supporting Document	Explanatory memorandum and statement of variables	Replaced	No
Form (revised)	Accident Insurance Policy	Approved-Closed	Yes
Form	Accident Insurance Policy	Replaced	Yes
Form	Application Accident Insurance	Approved-Closed	Yes
Form	Blank Endorsement	Approved-Closed	Yes
Form	[Higher] Education Benefit	Approved-Closed	Yes
Form	Common Carrier Benefit	Approved-Closed	Yes
Form	Common Disaster Benefit	Approved-Closed	Yes
Form	Carjacking Benefit	Approved-Closed	Yes
Form	Felonious Assault Benefit	Approved-Closed	Yes
Form	Rehabilitation Benefit	Approved-Closed	Yes
Form	Seat Belt [/Air Bag] Benefit	Approved-Closed	Yes
Form	Identity Theft Resolution Services Benefit	Approved-Closed	Yes
Rate	Exhibit I	Approved-Closed	Yes

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Product Name: Accident Insurance Policy
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 12/08/2009
Submitted Date 12/08/2009

Respond By Date

Dear Patricia Chudik,

This will acknowledge receipt of the captioned filing.

Objection 1

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Objection 2

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

With respect to coverage for minors for whom the insured has filed a petition to adopt please refer to the 60-day period outlined under ACA 23-79-137.

Objection 3

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

Section XII - Important Notice, must follow the guidelines under our Bulletin 15-2009.

Objection 4

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Dismemberment
 Product Name: Accident Insurance Policy
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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 02/09/2010
 Submitted Date 02/09/2010

Dear Rosalind Minor,

Comments:

Thank you for your correspondence regarding this filing.

Please allow me to apologize for the delay in our response.

Response 1

Comments: We have revised our policy form in accordance with your comments. We have made corresponding changes to the statement of variables.

Related Objection 1

Applies To:

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accident Insurance Policy	U-IMC-100-A AR (08/09)		Policy/Contract/Fraternal Certificate	Initial		60.000	U-IMC-100-A AR Individual

SERFF Tracking Number: ZURC-126395461 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 44259
 Company Tracking Number: CW AH 29319
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: Accident Insurance Policy
 Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319

Accident
Insurance
Policy
obj.pdf

Previous Version

Accident Insurance Policy	U-IMC-100-A AR (08/09)	Policy/Contract/Fraternal Certificate	Initial	60.000	U-IMC-100-A AR Individual Accident Insurance Policy.pdf
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No Rate/Rule Schedule items changed.

Response 2

Comments: We have revised our policy form in accordance with your comments. We have made corresponding changes to the statement of variables.

Related Objection 1

Applies To:

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

With respect to coverage for minors for whom the insured has filed a petition to adopt please refer to the 60-day period outlined under ACA 23-79-137.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accident Insurance	U-IMC-		Policy/Contract/Fraternal	Initial		60.000	U-IMC-

SERFF Tracking Number: ZURC-126395461 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 44259
 Company Tracking Number: CW AH 29319
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Product Name: Accident Insurance Policy
 Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319
 Policy 100-A AR Certificate 100-A AR
 (08/09) Individual Accident Insurance Policy obj.pdf

Previous Version

Accident Insurance Policy U-IMC-100-A AR (08/09) Policy/Contract/Fraternal Initial Certificate 60.000 U-IMC-100-A AR Individual Accident Insurance Policy.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: We have revised our policy form in accordance with your comments.

Related Objection 1

Applies To:

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

Section XII - Important Notice, must follow the guidelines under our Bulletin 15-2009.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accident Insurance	U-IMC-		Policy/Contract/Fraternal Initial			60.000	U-IMC-

<i>SERFF Tracking Number:</i>	<i>ZURC-126395461</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>44259</i>
<i>Company Tracking Number:</i>	<i>CW AH 29319</i>		
<i>TOI:</i>	<i>H03I Individual Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03I.000 Health - Accidental Death & Dismemberment</i>
<i>Product Name:</i>	<i>Accident Insurance Policy</i>		
<i>Project Name/Number:</i>	<i>CW AH 29319 - Accident Insurance Policy /CW AH 29319</i>		
Policy	100-A AR (08/09)	Certificate	100-A AR Individual Accident Insurance Policy obj.pdf

Previous Version

<i>Accident Insurance Policy</i>	<i>U-IMC-100-A AR (08/09)</i>	<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial 60.000</i>	<i>U-IMC-100-A AR Individual Accident Insurance Policy.pdf</i>
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No Rate/Rule Schedule items changed.

Response 4

Comments: We have revised our policy form in accordance with your comments.

Related Objection 1

Applies To:

- Accident Insurance Policy, U-IMC-100-A AR (08/09) (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Explanatory memorandum and statement of variables

Comment:

Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability Attach
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<i>SERFF Tracking Number:</i>	<i>ZURC-126395461</i>	<i>State:</i>	<i>Arkansas</i>			
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>44259</i>			
<i>Company Tracking Number:</i>	<i>CW AH 29319</i>					
<i>TOI:</i>	<i>H03I Individual Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03I.000 Health - Accidental Death & Dismemberment</i>			
<i>Product Name:</i>	<i>Accident Insurance Policy</i>					
<i>Project Name/Number:</i>	<i>CW AH 29319 - Accident Insurance Policy /CW AH 29319</i>					
	Number	Date		Specific Data	Score	Document
Accident Insurance Policy	U-IMC-100-A AR (08/09)	Policy/Contract/Fraternal Certificate	Initial		60.000	U-IMC-100-A AR Individual Accident Insurance Policy obj.pdf
<i>Previous Version</i>						
<i>Accident Insurance Policy</i>	<i>U-IMC-100-A AR (08/09)</i>	<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial</i>		<i>60.000</i>	<i>U-IMC-100-A AR Individual Accident Insurance Policy.pdf</i>

No Rate/Rule Schedule items changed.

Please contact me if you have additional questions or concerns.

Sincerely,
Karen Falbo, Patricia Chudik

SERFF Tracking Number: ZURC-126395461 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 44259
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TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Accident Insurance Policy
Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319

Note To Filer

Created By:

Rosalind Minor on 01/26/2010 08:30 AM

Last Edited By:

Rosalind Minor

Submitted On:

02/10/2010 09:43 AM

Subject:

Objection letter of 12/8/09

Comments:

Our records indicate that we have not received a response to our Objection Letter of 12/8/09. If you need more time to respond, please let us know immediately.

If we do not hear from you by 2/5/10, the filing will be disapproved.

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 Dismemberment
 Product Name: Accident Insurance Policy
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Form Schedule

Lead Form Number: U-IMC-100-A

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/10/2010	U-IMC-100-A AR (08/09)	Policy/Cont ract/Fratern al	Accident Insurance Policy Certificate	Initial		60.000	U-IMC-100-A AR Individual Accident Insurance Policy obj.pdf
Approved-Closed 02/10/2010	U-IMC-101-A AR (08/09)	Application/ Enrollment Form	Application Accident Insurance	Initial		52.000	U-IMC-101-A AR Application.pdf
Approved-Closed 02/10/2010	U-IMC-104-A CW (08/09)	Policy/Cont ract/Fratern al	Blank Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		55.000	U-IMC-104-A CW Blank Endorsement. pdf
Approved-Closed 02/10/2010	U-IMC-110-A CW (08/09)	Policy/Cont ract/Fratern al	[Higher] Education Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.000	U-IMC-110-A CW [Higher] Education Benefit.pdf
Approved-Closed 02/10/2010	U-IMC-111-A CW (08/09)	Policy/Cont ract/Fratern al	Common Carrier Benefit	Initial		48.000	U-IMC-111-A CW Common Carrier

<i>SERFF Tracking Number:</i>	<i>ZURC-126395461</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>44259</i>	
<i>Company Tracking Number:</i>	<i>CW AH 29319</i>			
<i>TOI:</i>	<i>H031 Individual Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H031.000 Health - Accidental Death & Dismemberment</i>	
<i>Product Name:</i>	<i>Accident Insurance Policy</i>			
<i>Project Name/Number:</i>	<i>CW AH 29319 - Accident Insurance Policy /CW AH 29319</i>			
	Certificate:		Benefit.pdf	
	Amendmen			
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved- Closed 02/10/2010 (08/09)	U-IMC-112- A CW (08/09)	Policy/Cont Common Disaster ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 52.000	U-IMC-112-A CW Common Disaster Benefit.pdf
Approved- Closed 02/10/2010 (08/09)	U-IMC-113- A CW (08/09)	Policy/Cont Carjacking Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 44.000	U-IMC-113-A CW Carjacking Benefit.pdf
Approved- Closed 02/10/2010 (08/09)	U-IMC-114- A CW (08/09)	Policy/Cont Felonious Assault ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 50.000	U-IMC-114-A CW Felonious Assault Benefit.pdf
Approved- Closed 02/10/2010 (08/09)	U-IMC-115- A AR (08/09)	Policy/Cont Rehabilitation Benefit ract/Fratern al Certificate:	Initial 47.000	U-IMC-115-A AR Rehabilitation Benefit.pdf

Accident Insurance Policy



ZURICH AMERICAN INSURANCE COMPANY

1400 American Lane
Schaumburg, Illinois 60196

In consideration of the application and payment of premiums, **We** agree to pay the benefits of this **Policy** to the person(s) 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** is guaranteed renewable [until **You** reach age [70]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.

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

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

**THIS IS AN ACCIDENT [ONLY] INSURANCE POLICY
[AND IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE].**

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

10-DAY RIGHT TO EXAMINE AND CANCEL POLICY: If **You** are not satisfied, **You** may cancel this **Policy** by returning it to **Us** or **Our** agent and by giving written notice of cancellation any time before midnight of the tenth day following the date of purchase. Notice of cancellation may be given personally or by mail to **Us** at the address shown above. In such case this **Policy** will be considered void as though it was never issued and any premium paid will be refunded.

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

TABLE OF CONTENTS

SECTION	DESCRIPTION
Section I	SCHEDULE
Section II	ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE
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	COVERAGE
Section XII	IMPORTANT NOTICE

SECTION I - SCHEDULE

I. **POLICYHOLDER:** [John Doe]
 [123 Main Street]
 [Anywhere, XX 10011]
 [COVERED DEPENDENTS: Jane Doe
 Billy Doe
 Sally Doe]

II. **POLICY NUMBER:** [ABC-1234567]

III. **POLICY INCEPTION DATE:** [01/01/2010]

IV. **POLICY PERIOD:** [Policy Inception Date] to [Expiration Date] [Continuous]
 (All Insurance begins and ends at 12:01 a.m. at **Policyholder's** Address)

V. **PREMIUM:** [\$00.00] Payable [Monthly]

VI. **CONTRACT SITUS:** []

VII. **PRINCIPAL SUM:** [\$1,000,000]

[The **Principal Sum** for covered **Dependents** will be a percentage of **Your Principal Sum** on the date of **Accident**, determined by multiplying **Your Principal Sum** by the percentage below.

<u>Plan Selected</u>	<u>% Spouse [or Domestic Partner]</u>	<u>% Child(ren)</u>
Spouse [or Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse [or Domestic Partner] and Dependent Child(ren)	[40%]	[10%]

VIII. **COVERAGE:**

COVERAGE	COVERED PERSON(S)	COVERAGE AMOUNT
[Accidental Death [and Dismemberment] Coverage]	[All]	[Accidental Death [100% of Principal Sum]]
		[Loss of: 1. Both Hands or Both Feet [100% of Principal Sum] 2. One Hand and One Foot [100% of Principal Sum] 3. One Hand or One Foot plus the loss of Sight of One Eye [100% of Principal Sum] 4. Sight of Both Eyes [100% of Principal Sum] 5. Speech and Hearing [100% of Principal Sum] 6. Speech or Hearing [50% of Principal Sum] 7. One Hand; One Foot; or Sight of One Eye [50% of Principal Sum] 8. Thumb and Index Finger of the same Hand [25% of Principal Sum] 9. Hearing in One Ear [25% of Principal Sum]]
[Exposure and Disappearance Coverage]	[All]	[100% of Principal Sum]
[]	[All]	[]

[IX. BENEFIT RIDERS:

BENEFIT	COVERED PERSON(S)	BENEFIT AMOUNT	FORM NUMBER
[[Higher] Education Benefit]]	[All]	[[10%] of the [Covered Person's] [Policyholder's] Principal Sum] or [\$10,000]]	[U-IMC-]
[Common Carrier Benefit]	[All]	[[50,000] or to a maximum of [50%] of the [Covered Person's] [Policyholder's] Principal Sum]	[U-IMC-]
[Common Disaster Benefit]	[All]	[\$500,000]	[U-IMC-]
[Carjacking Benefit]	[All]	[[10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]]	[U-IMC-]
[Felonious Assault Benefit]	[All]	[[15%] of the [Covered Person's] [Policyholder's] Principal Sum]	[U-IMC-]
[Identity Theft Resolution Services]	[All]	[Identity Theft Resolution Services]	[U-IMC-]
[Rehabilitation Benefit]	[All]	[[10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]]	[U-IMC-]
[Seat Belt/[Air Bag] Benefit]	[All]	[Seat Belt - [10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]] [Air Bag - [10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]]	[U-IMC-]
[]	[All]	[]	[U-IMC-]

X. REPORTING AND NOTICE ADDRESSES:

Claim Reporting:

[Claims Department
 Zurich American Insurance Company,
 [P.O. Box 968041, Schaumburg, IL. 60196]]
 [1-866-841-4771]

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

[ELIGIBILITY OF DEPENDENTS

When **You** enroll **You** may elect to cover **Your** eligible **Dependents**. An eligible **Dependent** includes **Your Spouse** [or **Domestic Partner**] and **Your Dependent Child(ren)**, [and] [**Your Spouse's Dependent Child(ren)**] [, and **Your Domestic Partner's Dependent Child(ren)**].]

YOUR EFFECTIVE DATE

Your coverage under this **Policy** begins on the Policy Inception Date shown in the Schedule provided:

1. **Your** application is approved by **Us**; and
2. the first premium is received by **Us** in accordance with the **Policy** provisions.

[ELIGIBLE DEPENDENTS EFFECTIVE DATE

An eligible **Dependent'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 **Dependent's** coverage is paid;
3. the date the person qualifies as a **Dependent**;
4. the date on which written enrollment for the **Dependent** is received by **Us**.

Your child born while this **Policy** is in force is covered from the moment of birth for a period of 90 days. An adopted newborn child of an **Insured** is covered from the moment of birth for a period of 90 days. After this time, the child will remain covered only if **You** have provided written notice of birth or the filing of a petition for adoption to **Us** and paid the required premium due, if any.

Your newly adopted child is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of 60 days. After this time, the child will remain covered only if **You** have provided written notice to **Us** of the adoption or the filing of a petition for adoption, and paid the required premium due, if any.

If **You** did not elect coverage for **Your Dependents** at the time of application or from the date of birth or adoption as permitted herein, and wish to add such coverage at a later time, **You** must apply for the additional insurance and pay any additional premium, and the additional person(s) must be added by endorsement. The date on the endorsement will determine when the additional person's coverage 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.

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

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 **Covered Person** is insured under this **Policy**, 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**.

Covered Person means any person who has insurance under the terms of this **Policy**. It includes **You** [and **Your Spouse** [or **Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering **Your Spouse** [or **Domestic Partner**] and/or **Dependent Child(ren)** is selected].

[**Dependent** means **Your Spouse** [or **Domestic Partner**] and **Dependent Child(ren)**, as defined in this section. [**Your Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.]]

[**Dependent Child(ren)** means **Your** unmarried **Child(ren)** and those of **Your Spouse** [or **Domestic Partner**] who rely on **You** for support, and are either: 1) less than 19 (nineteen) years of age; 2) less than 25 (twenty-five) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or

her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.]

[Domestic Partner means a person who meets the following requirements:

1. **You** 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. **You** 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. **You** and the **Domestic Partner** must both be at least 18 years of age;
4. neither **You** nor the **Domestic Partner** are legally married;
5. **You** and the **Domestic Partner** are not related by blood or adoption; and
6. **You** and the **Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely.

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

1. the **Domestic Partner** being named as the primary beneficiary in the event of **Your** death under **Your** retirement plan or 401(k) plan, if **You** maintain such a plan;
2. at least one of the following:
 - a. designation of the **Domestic Partner** as a primary beneficiary under **Your** will; or
 - b. designation of the **Domestic Partner** as a primary beneficiary for **Your** 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 **Us**.
5. the individual qualifies as a **Domestic Partner** under the law of the state of residence, if applicable.]

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 **You** by blood or marriage.

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

Policy means this Accident Insurance Policy.

Policyholder means the person to whom this **Policy** is issued, as stated in the Schedule.

Principal Sum means the amount of insurance applicable to a **Covered Person** as stated in the Schedule.

Related means **Your Spouse** [or **Domestic Partner**] or other adult living with **You**, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Spouse means **Your** legally married **Spouse** [under age 70].

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

You or **Your** means the **Policyholder**.

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 (sane or insane) 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. Reserve or National Guard active duty training is not excluded, unless it extends beyond thirty-one (31) consecutive days. 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 felony, riot or insurrection.
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
7. being intoxicated:
 - a. A **Covered Person** 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 **Covered Person'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 being under the influence of any controlled substance unless administered on the advice of a **Physician**.
13. [any condition for which the **Covered Person** is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.]

SECTION V – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If a **Covered Person** 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 Benefits. If a **Covered Person** can recover benefits under more than one of the Coverages or Benefits as stated in the Schedule as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

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.
- B. **Grace Period.** Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If **You** do 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 **Policy** will stay in force.
- 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 **You**. **We** may also change premium at any time when any change, agreed

upon in writing, between **You** 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.

- D. Reinstatement. If this **Policy** lapses due to non-payment of premium, it may be reinstated provided **We** receive from **You** a written application for reinstatement and the required premium payment within one (1) year after the date coverage lapsed. **Your Policy** will be reinstated upon **Our** approval of the application or, lacking such approval, upon the forty-fifth (45th) day following the date of **Our** receipt of premium unless **We** have previously notified **You** in writing of disapproval of the application.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than sixty (60) days before the date of reinstatement.

The reinstated policy will cover loss from a **Covered Injury**. However, the reinstated policy will not cover loss from an injury sustained between the date this **Policy** lapsed and the date it was reinstated.

Changes may be made in this **Policy** in connection with the reinstatement. These changes will be sent to **You** for **You** to attach to this **Policy**. In all other respects, **You** and **We** will have the same rights as before this **Policy** lapsed.

SECTION VII - TERMINATION OF INSURANCE

- A. Policy Renewal and Termination.

Renewal. This **Policy** is guaranteed renewable [until **You** reach age [70]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.

You may terminate this **Policy** at any time by delivering to **Us** a written notice to end this **Policy** effective on receipt or such later date as **You** specify in the notice. **We** will calculate and return the unearned premium, if any, using a standard short rate table. **You** must send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

This **Policy** and all insurance for **You** [and **Your Dependents**] will terminate on the earliest of the following:

1. On any premium due date if the payment is not received prior to the end of the Grace Period;
2. On the date **You** reach age [70];
3. On the date of **Your** death;
4. On the date there is fraud or a material misrepresentation made by or with the knowledge of any **Covered Person** in filing a claim for benefits.

- B. [Termination of **Dependent's** Insurance.

All insurance for a **Dependent** will terminate on the earliest of the following:

1. On the date that this **Policy** is terminated;
2. On any premium due date if the premium for that **Dependent** is not received prior to the end of the Grace Period;
3. On the date the **Dependent** reaches age [70];
4. On the first premium due date following the date the person no longer qualifies as a **Dependent**.]

Termination of this **Policy** or of any **Covered Person's** coverage 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. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within [twenty (20)] days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name the **Covered Person** who sustained the injury and the **Policyholder**. To request a claim form, contact **Us** at [1-866-841-4771.] The notice must be sent to the address shown in 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 and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

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 the **Policyholder**. **Covered Losses** resulting from **Your** 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 **You**, **We** will pay the benefit to **Your** survivors in the following order:
 - a. **Your Spouse [or Domestic Partner]**;
 - b. **Your** child(ren);
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.

Upon the death of a **Policyholder**, the proceeds payable to the named beneficiary shall include premiums paid for accident and health insurance coverage for the insured for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in a lump sum on a date no later than thirty (30) days after the proof of the **Policyholder's** death has been furnished to **Us**.

2. [Loss of Life of a **Covered Person** other than the **Policyholder**. **Covered Losses** for the death of a **Covered Person** other than **You** will be paid to **You**. If **You** predecease or die at the same time as the **Covered Person**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.]
3. All Other Claims. Benefits are to be paid to **You**. **You** may direct in writing that all, or part of a benefit, if applicable, will be paid directly to the party who furnished the service. The direction may be changed at any time up to the filing of the proof of **Covered Loss**.
4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

SECTION X - GENERAL POLICY CONDITIONS

- A. Beneficiaries. **You** have 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, **You** may change the beneficiary at any time unless **You** have assigned the interest in this **Policy**. In such case, the person to whom the interest in this **Policy** is assigned 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 approved by one of **Our** executive officers. The approval must be endorsed hereon or attached hereto. 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 any coverage which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.

- D. Conformity with Statute. Terms of this **Policy** which, on its effective date, conflict with the statutes of the state, District of Columbia, or territory in which **You** reside on such date are amended to conform to the minimum requirements of such laws.
- E. Entire Contract. This **Policy**, **Your** application, Benefit Riders, and any other attachments represent the entire insurance contract between the **Policyholder** and **Us**.
- F. 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 **Policyholder** 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.
- G. Physical Examination and Autopsy. **We** have the right to examine a **Covered Person** 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 in the event of death unless forbidden by law.
- H. [Reduction Schedule. [At age [70], the **Covered Person's Principal Sum** will be reduced based on the following schedule shown below for the **Covered Person's** attained age:

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

These reductions also apply if:

1. the **Covered Person** becomes covered under the **Policy**; or
 2. the **Covered Person's** coverage increases on or after the date the **Covered Person** attains age [70].]
- I. Time Limit on Certain Defenses. In the absence of fraud, statements made by a **Covered Person** 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 three (3) years from the date coverage starts no such statement (except age) will cause this **Policy** to be contested.
 - J. 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 **Policyholder**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Policyholder** 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 a **Covered Person**.]

SECTION XI – COVERAGE

[ACCIDENTAL DEATH [AND DISMEMBERMENT]] COVERAGE

If [a **Covered Person**] **[You]** [or **Your** covered **Spouse** [or **Domestic Partner**]] [suffer[s] a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

[If a **Covered Injury** to [a **Covered Person**] **[You]** [or **Your** covered **Spouse** [or **Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	Benefit
1. [Both Hands or Both Feet	[100% of Principal Sum]]

- | | |
|--|----------------------------------|
| 2. [One Hand and One Foot | [100% of Principal Sum]] |
| 3. [One Hand or One Foot plus the loss of Sight of One Eye | [100% of Principal Sum]] |
| 4. [Sight of Both Eyes | [100% of Principal Sum]] |
| 5. [Speech and Hearing | [100% of Principal Sum]] |
| 6. [Speech or Hearing | [50% of Principal Sum]] |
| 7. [One Hand; One Foot; or Sight of One Eye | [50% of Principal Sum]] |
| 8. [Thumb and Index Finger of the same Hand | [25% of Principal Sum]] |
| 9. [Hearing in One Ear | [25% of Principal Sum]] |

For purposes of this coverage:

Covered Loss means:

1. For a foot or hand, actual severance through or above an ankle or wrist joint;
2. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.]

[EXPOSURE AND DISAPPEARANCE COVERAGE

If [a **Covered Person** is] [You are] exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

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

SECTION XII – IMPORTANT NOTICE

The [Insured] [Covered Person] may call [XXX-XXX-XXXX] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the [Insured] [Covered Person] can write to Zurich American Insurance Company at their administrative office at [1400 American Lane, Schaumburg, IL 60196]. The [Insured] [Covered Person] may also call their agent [XXXXXX] at [XXX-XXX-XXXX] or write to their agent at [XXXXXXXXXXXXXXXXXXXXXXX] if they need assistance in resolving any complaints

If we at Zurich American Insurance Company or should the [Insured] [Covered Person] wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the [Insured] [Covered Person] may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].

Application

Accident Insurance



Zurich American Insurance Company
 1400 American Lane
 Schaumburg, Illinois 60196

APPLICANT 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 Policy Inception Date:		Policy Number (assigned by the Company):	

SPOUSE [or DOMESTIC PARTNER] INFORMATION (if Applicant is applying for Dependent coverage)			
Full Legal Name (First, Middle Initial and Last):		Home Phone: - -	
Street Address (if different than Applicant's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		

DEPENDENT CHILD(REN) INFORMATION (if Applicant is applying for Dependent coverage)		
Full Legal Name (First, Middle Initial and Last):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):
Full Legal Name (First, Middle Initial and Last):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY):

INSURANCE REQUESTED	
Plan Selected (please check each box that applies):	Principal Sum (coverage amount)
<input type="checkbox"/> Applicant	\$
<input type="checkbox"/> Spouse [or Domestic Partner] Only]	[as per the Policy Schedule]
<input type="checkbox"/> Dependent Child(ren) Only]	[as per the Policy Schedule]
<input type="checkbox"/> Spouse [or Domestic Partner] and Dependent Child(ren)]	[as per the Policy Schedule]
[The Principal Sum for Covered Dependents will be a percentage of the Applicant's Principal Sum .]	
[Coverage(s) Included:	Coverage Amount
[Accidental Death Coverage]	[as per the Policy Schedule]
[Dismemberment Coverage]	[as per the Policy Schedule]
[Exposure and Disappearance Coverage]	[as per the Policy Schedule]
[]	[as per the Policy Schedule]

Benefit(s) Included:	Benefit Amount
[[Higher] Education Benefit]	[as per the Policy Schedule]
[Common Carrier Benefit]	[as per the Policy Schedule]
[Common Disaster Benefit]	[as per the Policy Schedule]
[Carjacking Benefit]	[as per the Policy Schedule]
[Felonious Assault Benefit]	[as per the Policy Schedule]
[Identity Theft Resolution Services]	[as per the Policy Schedule]
[Rehabilitation Benefit]	[as per the Policy Schedule]
[Seat Belt/[Air Bag] Benefit]	[as per the Policy Schedule]
[]	[as per the Policy Schedule]]

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

PREMIUM INFORMATION:	
Annual 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 The Applicant must complete a separate authorization form for a Credit Card or Bank Draft payment.	

INSURANCE 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 Applicant hereby applies for Accident Insurance and declares that:

All information provided in this application and any attachments hereto is true and correct. The undersigned understands that all information provided in this application 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 Application.

This Application shall be made part of the **Policy**, if issued.

Applicant's Signature (may be electronic):

Date:

[FOR COMPANY USE ONLY]

[SPONSORING ORGANIZATION INFORMATION	
---	--

Legal Name:	ID Number:]
-------------	--------------

[PRODUCER INFORMATION	
------------------------------	--

Writing Agent or Broker Name:	Producer Number:]
-------------------------------	--------------------

Blank 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 **Your 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 changes to the **Policy**, which are administrative in nature: (1) changes to the Schedule; (2) addition or deletion of Covered Dependents; and (3) other administrative changes to the **Policy**.]

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. _____

[Higher] Education 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 **Your Policy**.

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

If **You** [or **Your Spouse** [or **Domestic Partner**]] [selects a **Plan** covering **Dependent Child(ren)** and **You**] suffer a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] Coverage, **We** will pay an additional benefit for [higher] education expenses to the individual who incurs the expense for each **[Covered] Dependent Child**.

[A **Dependent Child** is eligible for the [Higher] Education Benefit if on the date of the **Covered Accident**:

1. he or she is enrolled as a full-time **Student** in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Covered Accident**.]

The [Higher] Education Benefit will be equal to the amount shown on the Schedule per **Dependent Child**. [This amount will be paid annually for up to [four (4)] consecutive years if the **[Covered] Dependent Child** continues his or her education. Before this benefit is paid each year, the **[Covered] Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.]

[If, at the time of the **Covered Accident**, a **Plan** covering **Dependents** was selected, but there are no **Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [\$1,000] to the designated beneficiary.]

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 **Your Policy** ([Policy No. _____])

Common Carrier 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 **Your Policy**.

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

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death [and Accidental Dismemberment]] Coverage, **We** will pay an additional benefit equal to the amount shown in the Schedule, provided the **Covered Injury** is sustained while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit only, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire; and
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.

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 **Your Policy** ([Policy No. _____])

Common Disaster 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 **Your Policy**.

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

If **You** select a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse** [or **Domestic Partner**] are both eligible for [Accidental Death] Coverage as a result of **Covered Injuries** suffered in the same **Covered Accident** [and within [90 days] of such **Covered Accident**,] the **Principal Sum** that would have been payable because of **Your Covered Spouse's** [or **Domestic Partner's**] **Accidental Death** will be increased to equal that payable for **Your Covered Loss**, provided [: **You** and **Your Covered Spouse** [or **Domestic Partner**] are survived by one or more **Covered Dependent Child(ren)**; and] the combined benefits of **You** and **Your Covered Spouse** [or **Domestic Partner**] are not more than the amount shown in the Schedule.

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

Covered Dependent Child(ren) means [an] eligible **Dependent Child(ren)** who has insurance under the terms of this rider.

Covered Spouse [or **Domestic Partner**] means an eligible **Spouse** [or **Domestic Partner**] who has insurance under the terms of this rider.

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 **Your Policy** ([Policy No. _____])

Carjacking 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 **Your Policy**.

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

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and Accidental Dismemberment] Coverage, as a direct result of a **Covered Accident** that occurs during a **Carjacking** of a private passenger vehicle that the [**Covered Person** was] [**You** were] operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to the amount shown in the Schedule.

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24) hours] of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24) hours] or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit only, **Carjacking** means a person other than [a **Covered Person**] [**You**] taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.

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 **Your Policy** ([Policy No. _____])

Felonious Assault 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 **Your Policy**.

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

If **You** suffer a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and Accidental Dismemberment] Coverage as a result of a violent or criminal act committed by someone other than **You**, [a **Fellow Employee**] or a member of **Your Family** or **Household**, **We** will pay an additional benefit equal to the amount shown in the Schedule.

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

[Fellow Employee] means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the defined violent crime/felonious assault was committed.]

Family means **Your** parent, stepparent, **Spouse** [or **Domestic Partner**] or former **Spouse** [or **Domestic Partner**], son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

Household means a person who maintains residence at the same address as **You**.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.

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 **Your Policy** ([Policy No. _____])

Rehabilitation 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 **Your Policy**.

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

If [**You** suffer][a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Dismemberment] Coverage, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2) years] from the date of the **Covered Accident** for the **Rehabilitation Training**; or
2. the maximum amount shown in the Schedule.

Pre-existing Condition Limitation: We will not pay benefits for **Rehabilitation Training** which is the result of a **Pre-existing condition**.

For this benefit only, the following definitions apply:

Rehabilitation Training means a treatment program that:

1. is prescribed by a **Physician** that is approved by **Us** prior to the provision of services;
2. is required due to [**Your**] [the **Covered Person's**] **Covered Injury**; and
3. prepares [**You**] [the **Covered Person**] for an occupation that he or she would not have engaged in except for the **Covered Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

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

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 **Your Policy** ([Policy No. _____])

Seat Belt[/Air Bag] 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 **Your Policy**.

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

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] Coverage, and the **Covered Injury** which caused the **Accidental** death directly resulted from an automobile **Covered Accident**, **We** will pay an additional Seat Belt Benefit, which equals the amount shown in the Schedule, provided that the [the **Covered Person** was] [**You** were]:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional **Air Bag Benefit** equal to the amount shown in the Schedule will be paid if [the **Covered Person** was] [**You** were] driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided [the **Covered Person's**] [**Your**] seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.]

[**We** will not pay a Seat Belt [or Air Bag] Benefit if the [**Covered Person**] [**Insured**] that was driving the motor vehicle was either:

1. under the influence of alcohol;
 - a. A driver will be conclusively presumed to be legally 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 **Covered Accident** occurred.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or,
2. 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.]

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 **Your Policy** ([Policy No. _____])

Identity Theft Resolution Services 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 **Your Policy**.

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

For a **Covered Person** who is the victim of **Identity Theft** while covered under this **Policy**, **We** will provide the **Covered Person** with access to **Identity Theft Resolution Services** provided by a consumer fraud specialist who will assist the **Covered Person** in the process of restoring their identity. Any act or series of acts committed by any one person or group of persons acting in concert or in which any one person or group of persons is concerned or implicated is considered to be one **Identity Theft**, even if a series of acts continues into a subsequent policy period.

IDENTITY THEFT RESOLUTION SERVICES EXCLUSIONS

We will not cover expenses under this additional benefit for any loss other than **Identity Theft Resolution Services**.

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

Identity Theft means the act of knowingly transferring or using, without lawful authority, a means of identification of a **Covered Person** with the intent to commit, or to aid or abet, any unlawful activity that constitutes a violation of federal law or a felony under any applicable state or local law.

Identity Theft Resolution Services means the assistance of a personal advocate assigned to a **Covered Person** who is the victim of **Identity Theft** while covered under the **Policy**. It also includes ordering credit reports, alerting credit reporting agencies, providing credit and fraud monitoring, and preparing necessary documentation and letters.

Identity Theft Resolution Services will also include free **Identity Theft** monitoring services for a twelve (12) month period for any **Covered Person** who is the victim of **Identity Theft** while covered under this **Policy**. **Identity Theft Resolution Services** will also provide free **Identity Theft** monitoring services for a twelve (12) month period for any **Covered Person** who becomes incapacitated or deceased while covered under this **Policy**. The twelve (12) month period for providing **Identity Theft Resolution Services** will begin on the date **We** receive written notice, in accordance with the provisions of Section VIII of the **Policy**, that a **Covered Person** is either the victim of **Identity Theft**, has become incapacitated or is deceased. Incapacitated or incapacitation is defined as any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person.

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 **Your Policy** ([Policy No. _____])

SERFF Tracking Number: ZURC-126395461 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 44259
 Company Tracking Number: CW AH 29319
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: Accident Insurance Policy
 Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 02/10/2010	Exhibit I	U-IMC-100-A AR, New U-IMC-110-A CW, U-IMC-111-A CW, U-IMC-112-A CW, U-IMC-118-A CW, U-IMC-114-A CW, U-IMC-115-A AR, U-IMC-116-A AR, U-IMC-113-A CW			ZNA02.MCM.Individual.50%.Rates.20090904.pdf

Exhibit I
 Zurich American Insurance Company
 Accident Insurance Policy U-IMC-100-A
 Annual Premiums

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Accidental Death	\$1,000	100%	N/A	\$0.64000
Accidental Dismemberment	\$1,000	Varies**	7.50%	\$0.04800

**Pro-Rate for Other Maximum Benefits*

Adjustment Factor for Different Incurral Periods Following Accident

Time for Loss to Occur	90 Days	120 Days	180 Days	365 Days
Adjustment Factor	95.0%	95.5%	96.5%	100.0%

**Accidental Dismemberment: Covered Loss	Percent of Principle Sum
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%

Exhibit I
 Zurich American Insurance Company
 Higher Education Benefit U-IMC-110-A
 Annual Premiums

Benefit	Unit of Principle Sum	Average Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Higher Education Benefit	\$1,000	10%	10.00%	\$0.06400

**Pro-Rate for Other Benefit Percentages*

Exhibit I
 Zurich American Insurance Company
 Common Carrier Benefit U-IMC-111-A
 Annual Premiums

Benefit	Unit of Principle Sum	Average Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Common Carrier Benefit	\$1,000	50%	1.10%	\$0.00704

**Pro-Rate for Other Benefit Percentages*

Exhibit I
Zurich American Insurance Company
Common Disaster Benefit U-IMC-112-A
Annual Premiums

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate	Annual Premium per Unit
Common Disaster Benefit	\$1,000	100%	0.60%	\$0.00384

Exhibit I
 Zurich American Insurance Company
 Carjacking Benefit U-IMC-113-A
 Annual Premiums

Benefit	Unit of Principle Sum	Average Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Carjacking Benefit	\$1,000	10%	0.02%	\$0.00013

**Pro-Rate for Other Benefit Percentages*

Exhibit I
Zurich American Insurance Company
Felony Assault Benefit U-IMC-114-A
Annual Premiums

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Felony Assault Benefit	\$1,000	10%	0.30%	\$0.00192

**Pro-Rate for Other Benefit Percentages*

Exhibit I
Zurich American Insurance Company
Rehabilitation Benefit U-IMC-115-A
Annual Premiums

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate	Annual Premium per Unit
Rehabilitation Benefit	\$1,000	10%	0.30%	\$0.00192

Exhibit I
 Zurich American Insurance Company
 Seat Belt/Air Bag Benefit U-IMC-116-A
 Annual Premiums

Benefit	Unit of Principle Sum	Average Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Seat Belt/Air Bag Benefit	\$1,000	10%	2.30%	\$0.01472

**Pro-Rate for Other Benefit Percentages*

Exhibit I
Zurich American Insurance Company
Identity Theft Resolution Services Benefit U-IMC-118-A
Annual Premiums

Benefit	Unit	Annual Premium per Unit
Identity Theft Resolution Services Benefit	Per Person	\$1.70000

SERFF Tracking Number: ZURC-126395461 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 44259
 Company Tracking Number: CW AH 29319
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: Accident Insurance Policy
 Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/10/2010
Comments:			
Attachment:			
	ZAIC Individual Accident Form Filing Certificate of Readability with OOC.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/10/2010
Bypass Reason:	Please see the form schedule. An application is included.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	02/10/2010
Comments:			
Attachment:			
	12-7-09Outline of Coverage AR.pdf		

Certificate of Readability



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-IMC-100-A (08/09)	Accident Insurance Policy	60
U-IMC-101-A (08/09)	Application	52
U-IMC-103-A (08/09)	Outline of Coverage	42
U-IMC-104-A (08/09)	Blank Endorsement	55
U-IMC-110-A (08/09)	[Higher] Education Benefit	50
U-IMC-111-A (08/09)	Common Carrier Benefit	48
U-IMC-112-A (08/09)	Common Disaster Benefit	52
U-IMC-113-A (08/09)	Carjacking Benefit	44
U-IMC-114-A (08/09)	Felonious Assault Benefit	50
U-IMC-115-A (08/09)	Rehabilitation Benefit	47
U-IMC-116-A (08/09)	Seat Belt [Air Bag] Benefit	42
U-IMC-118-A (08/09)	Identity Theft Resolution Services Benefit	37

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: Vice President, Accident & Health

Date: September 9, 2009

Outline of Coverage



ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

ACCIDENT [ONLY] COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

THIS IS AN ACCIDENT [ONLY] INSURANCE POLICY

[IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE]

OUTLINE OF COVERAGE FOR POLICY FORM SERIES U-IMC-100-A

Read Your Policy Carefully. This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Accident [Only] Coverage. Accident [only] coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident [ONLY], subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

COVERAGES

[Accidental Death [and Dismemberment]]

If [a **Covered Person**] [You] [or **Your** covered **Spouse** [or **Domestic Partner**]] [suffer[s] a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

[If a **Covered Injury** to [a **Covered Person**] [You] [or **Your** covered **Spouse** [or **Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	Benefit
1. Both Hands or Both Feet	[100% of Principal Sum]
2. One Hand and One Foot	[100% of Principal Sum]
3. One Hand or One Foot plus the loss of Sight of One Eye	[100% of Principal Sum]
4. Sight of Both Eyes	[100% of Principal Sum]
5. Speech and Hearing	[100% of Principal Sum]
6. Speech or Hearing	[50% of Principal Sum]
7. One Hand; One Foot; or Sight of One Eye	[50% of Principal Sum]

- 8. Thumb and Index Finger of the same Hand [25% of **Principal Sum**]
- 9. Hearing in One Ear [25% of **Principal Sum**]

For purposes of this coverage:

Covered Loss means:

- 1. For a foot or hand, actual severance through or above an ankle or wrist joint;
- 2. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
- 3. Total and permanent loss of sight;
- 4. Total and permanent loss of speech; or
- 5. Total and permanent loss of hearing.]

[Exposure and Disappearance Coverage

If [a **Covered Person** is] [You are] exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

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

[]

LIMITATIONS[, REDUCTIONS,] AND EXCLUSIONS

Limitation on Multiple Covered Losses. If a **Covered Person** 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 Benefits. If a **Covered Person** can recover benefits under more than one of the Coverages or Benefits as stated in the Schedule as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

[Reduction Schedule. [At age [70], the **Covered Person's Principal Sum** will be reduced based on the following schedule shown below for the **Covered Person's** attained age:

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

These reductions also apply if:

- 1. the **Covered Person** becomes covered under the **Policy**; or
- 2. the **Covered Person's** coverage increases on or after the date the **Covered Person** attains age [70].]

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, while sane or insane, or intentionally self-inflicted **Covered 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 Reserve or National Guard active duty training is not excluded, unless it extends beyond thirty-one (31) consecutive days. 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 felony, riot or insurrection.
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
7. being intoxicated:
 - a. A **Covered Person** 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 **Covered Person'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 being under the influence of any controlled substance unless administered on the advice of a **Physician**.
13. [any condition for which **You** are entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.]

RENEWAL

The **Policy** is guaranteed renewable [until **You** reach age [70]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.

[BENEFIT RIDERS

[[Higher] Education Benefit Rider

If **You** [or **Your Spouse** [or **Domestic Partner**]] [selects a **Plan** covering **Dependent Child(ren)** and **You**] suffer a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] Coverage, **We** will pay an additional benefit for [higher] education expenses to the individual who incurs the expense for each [**Covered**] **Dependent Child**.

[A **Dependent Child** is eligible for the [Higher] Education Benefit if on the date of the **Covered Accident**:

1. he or she is enrolled as a full-time **Student** in an accredited college, university or trade school; or
2. he or she is at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Covered Accident**.]

The [Higher] Education Benefit will be equal to [[10%] of the [**Covered Person's**] [**Policyholder's**] **Principal Sum**] or [\$10,000] per **Dependent Child**. [This amount will be paid annually for up to [four (4)] consecutive years if the [**Covered**] **Dependent Child** continues his or her education. Before this benefit is paid each year, the [**Covered**] **Dependent Child** must present written proof, acceptable to **Us**, that he or she is attending an institution of higher learning on a full-time basis.]

[If, at the time of the **Covered Accident**, a **Plan** covering **Dependents** was selected, but there are no **Dependent Child(ren)** who qualify for this benefit, **We** will pay an additional benefit of [\$1,000] to the designated beneficiary.]]

[Common Carrier Benefit Rider

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death [and Accidental Dismemberment]] Coverage, **We** will pay an additional benefit equal to [[\$50,000] or to a maximum of [50%] of the [**Covered Person's**] [**Policyholder's**] **Principal Sum**], provided the **Covered Injury** is sustained while a passenger riding in or on, boarding, or getting off a **Common Carrier**.

For purposes of this benefit only, **Common Carrier** means:

1. any land or water conveyance licensed to carry persons for hire; and
2. any civilian aircraft that holds a certificate of Public Convenience and Necessity, a license, or a similar permit for civilian scheduled air carriers issued by the country where the aircraft is registered.]

[Common Disaster Benefit Rider

If **You** select a **Plan** covering **Your Dependents** and **You** and **Your Covered Spouse** [or **Domestic Partner**] are both eligible for [Accidental Death] Coverage as a result of **Covered Injuries** suffered in the same **Covered Accident** [and within [90 days] of such **Covered Accident**.] the **Principal Sum** that would have been payable because of **Your Covered Spouse's** [or **Domestic Partner's**] **Accidental Death** will be increased to equal that payable for **Your Covered Loss**, provided [: **You** and **Your Covered Spouse** [or **Domestic Partner**] are survived by one or more **Covered Dependent Child(ren)**; and] the combined benefits of **You** and **Your Covered Spouse** [or **Domestic Partner**] are not more than [\$500,000].

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

Covered Dependent Child(ren) means [an] eligible **Dependent Child(ren)** who has insurance under the terms of this rider.

Covered Spouse [or **Domestic Partner**] means an eligible **Spouse** [or **Domestic Partner**] who has insurance under the terms of this rider.]

[Carjacking Benefit Rider

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and Accidental Dismemberment] Coverage, as a direct result of a **Covered Accident** that occurs during a **Carjacking** of a private passenger vehicle that the [**Covered Person** was] [**You** were] operating, getting into or out of, or riding in as a passenger, **We** will pay an additional benefit equal to [[10%] of the [**Covered Person's**] [**Policyholder's**] **Principal Sum** to a maximum of [\$10,000]].

Verification of the **Carjacking** must be made part of an official police report within [twenty-four (24) hours] of the **Carjacking** or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within [twenty-four (24) hours] or as soon as reasonably possible, and such verification must be provided to **Us**.

For purposes of this benefit only, **Carjacking** means a person other than [a **Covered Person**] [**You**] taking unlawful possession of a private passenger automobile by means of force or threats against the person(s) then rightfully occupying it.]

[Felonious Assault Benefit Rider

If **You** suffer a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] [and Accidental Dismemberment] Coverage as a result of a violent or criminal act committed by someone other than **You**, [a **Fellow Employee**] or a member of **Your Family** or **Household**, **We** will pay an additional benefit equal to [[15%] of the [**Covered Person's**] [**Policyholder's**] **Principal Sum**].

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

[**Fellow Employee** means a person employed by the same employer as **You** or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than [forty-five (45)] days prior to the date on which the defined violent crime/felonious assault was committed.]

Family means **Your** parent, stepparent, **Spouse** [or **Domestic Partner**] or former **Spouse** [or **Domestic Partner**], son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

Household means a person who maintains residence at the same address as **You**.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.]

[Rehabilitation Benefit Rider

If [**You** suffer] [a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Dismemberment] Coverage, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training**, in an amount equal to the lesser of:

1. the actual expenses that are incurred within [two (2) years] from the date of the **Covered Accident** for the **Rehabilitation Training**; or
2. [[10%] of the [**Covered Person's**] [**Policyholder's**] **Principal Sum** to a maximum of [\$10,000]].

Pre-existing Condition Limitation: We will not pay benefits for **Rehabilitation Training** which is the result of a **Pre-existing condition**

For this benefit only, the following definitions apply:

Rehabilitation Training means a treatment program that:

1. is prescribed by a **Physician** that is approved by **Us** prior to the provision of services;
2. is required due to [**Your**] [the **Covered Person's**] **Covered Injury**;
3. prepares [**You**] [the **Covered Person**] for an occupation that he or she would not have engaged in except for the **Covered Injury**;

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

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

[Seat Belt/Air Bag] Benefit Rider

If [a **Covered Person** suffers] [**You** suffer] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] Coverage, and the **Covered Injury** which caused the **Accidental** death directly resulted from an automobile **Covered Accident**, **We** will pay an additional Seat Belt Benefit, which equals [[10%] of the [**Covered Person's**] [**Policyholder's**] **Principal Sum** to a maximum of [\$10,000]], provided that the [the **Covered Person** was] [**You** were]:

1. operating or riding as a passenger in any private passenger motor vehicle designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Covered Injury**.

Verification of the actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Covered Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

[An additional Air Bag Benefit equal to [[10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]] will be paid if [the Covered Person was] [You were] driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided [the Covered Person's] [Your] seat belt or lap and shoulder restraint was properly fastened at the time of the Accident. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the Accident, through certification by the investigating officers or by other reasonable proof, acceptable to Us.]

[We will not pay a Seat Belt [or Air Bag] Benefit if the [Covered Person] [Insured] that was driving the motor vehicle was either:

1. under the influence of alcohol;
 - a. A driver will be conclusively presumed to be legally 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 Covered Accident occurred.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication; or
2. under the influence of any controlled substance unless administered on the advice of a Physician.]]

[Identity Theft Resolution Services Rider

For a Covered Person who is the victim of Identity Theft while covered under this Policy, We will provide the Covered Person with access to Identity Theft Resolution Services provided by a consumer fraud specialist who will assist the Covered Person in the process of restoring their identity. Any act or series of acts committed by any one person or group of persons acting in concert or in which any one person or group of persons is concerned or implicated is considered to be one Identity Theft, even if a series of acts continues into a subsequent policy period.

Identity Theft Resolution Services Exclusions

We will not cover expenses under this additional benefit for any loss other than Identity Theft Resolution Services.

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

Identity Theft means the act of knowingly transferring or using, without lawful authority, a means of identification of a Covered Person with the intent to commit, or to aid or abet, any unlawful activity that constitutes a violation of federal law or a felony under any applicable state or local law.

Identity Theft Resolution Services means the assistance of a personal advocate assigned to a Covered Person who is the victim of Identity Theft while covered under the Policy. It also includes ordering credit reports, alerting credit reporting agencies, providing credit and fraud monitoring, and preparing necessary documentation and letters.

Identity Theft Resolution Services will also include free Identity Theft monitoring services for a twelve (12) month period for any Covered Person who is the victim of Identity Theft while covered under this Policy. Identity Theft Resolution Services will also provide free Identity Theft monitoring services for a twelve (12) month period for any Covered Person who becomes incapacitated or deceased while covered under this Policy. The twelve (12) month period for providing Identity Theft Resolution Services will begin on the date We receive written notice, in accordance with the provisions of Section VIII of the Policy, that a Covered Person is either the victim of Identity Theft, has become incapacitated or is deceased. Incapacitated or incapacitation is defined as any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that he or she lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person.]

[]

SERFF Tracking Number: ZURC-126395461 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 44259
 Company Tracking Number: CW AH 29319
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
 Dismemberment Dismemberment
 Product Name: Accident Insurance Policy
 Project Name/Number: CW AH 29319 - Accident Insurance Policy /CW AH 29319

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/23/2009	Form	Accident Insurance Policy	02/09/2010	U-IMC-100-A AR Individual Accident Insurance Policy.pdf (Superseded)

Accident Insurance Policy



ZURICH AMERICAN INSURANCE COMPANY

1400 American Lane
Schaumburg, Illinois 60196

In consideration of the application and payment of premiums, **We** agree to pay the benefits of this **Policy** to the person(s) 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** is guaranteed renewable [until **You** reach age [70]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.

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

[BENEFITS ARE REDUCED UPON ATTAINMENT OF SPECIFIED AGES.]

**THIS IS AN ACCIDENT [ONLY] INSURANCE POLICY
[AND IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE].**

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

10-DAY RIGHT TO EXAMINE AND CANCEL POLICY: If **You** are not satisfied, **You** may cancel this **Policy** by returning it to **Us** or **Our** agent and by giving written notice of cancellation any time before midnight of the tenth day following the date of purchase. Notice of cancellation may be given personally or by mail to **Us** at the address shown above. In such case this **Policy** will be considered void as though it was never issued and any premium paid will be refunded.

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

TABLE OF CONTENTS

SECTION	DESCRIPTION
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Section V	GENERAL LIMITATIONS
Section VI	PREMIUMS
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Section VIII	HOW TO FILE A CLAIM
Section IX	PAYMENT OF CLAIMS
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Section XII	IMPORTANT NOTICE

SECTION I - SCHEDULE

I. **POLICYHOLDER:** [John Doe]
 [123 Main Street]
 [Anywhere, XX 10011]
 [COVERED DEPENDENTS: Jane Doe
 Billy Doe
 Sally Doe]

II. **POLICY NUMBER:** [ABC-1234567]

III. **POLICY INCEPTION DATE:** [01/01/2010]

IV. **POLICY PERIOD:** [Policy Inception Date] to [Expiration Date] [Continuous]
 (All Insurance begins and ends at 12:01 a.m. at **Policyholder's** Address)

V. **PREMIUM:** [\$00.00] Payable [Monthly]

VI. **CONTRACT SITUS:** []

VII. **PRINCIPAL SUM:** [\$1,000,000]

[The **Principal Sum** for covered **Dependents** will be a percentage of **Your Principal Sum** on the date of **Accident**, determined by multiplying **Your Principal Sum** by the percentage below.

<u>Plan Selected</u>	<u>% Spouse [or Domestic Partner]</u>	<u>% Child(ren)</u>
Spouse [or Domestic Partner] only:	[50%]	0
Dependent Child(ren) only:	0	[15%]
Spouse [or Domestic Partner] and Dependent Child(ren)	[40%]	[10%]

VIII. **COVERAGE:**

COVERAGE	COVERED PERSON(S)	COVERAGE AMOUNT
[Accidental Death [and Dismemberment] Coverage]	[All]	[Accidental Death [100% of Principal Sum]]
		[Loss of: 1. Both Hands or Both Feet [100% of Principal Sum] 2. One Hand and One Foot [100% of Principal Sum] 3. One Hand or One Foot plus the loss of Sight of One Eye [100% of Principal Sum] 4. Sight of Both Eyes [100% of Principal Sum] 5. Speech and Hearing [100% of Principal Sum] 6. Speech or Hearing [50% of Principal Sum] 7. One Hand; One Foot; or Sight of One Eye [50% of Principal Sum] 8. Thumb and Index Finger of the same Hand [25% of Principal Sum] 9. Hearing in One Ear [25% of Principal Sum]]
[Exposure and Disappearance Coverage]	[All]	[100% of Principal Sum]
[]	[All]	[]

[IX. BENEFIT RIDERS:

BENEFIT	COVERED PERSON(S)	BENEFIT AMOUNT	FORM NUMBER
[[Higher] Education Benefit]]	[All]	[[10%] of the [Covered Person's] [Policyholder's] Principal Sum] or [\$10,000]]	[U-IMC-]
[Common Carrier Benefit]	[All]	[[[\$50,000] or to a maximum of [50%] of the [Covered Person's] [Policyholder's] Principal Sum]	[U-IMC-]
[Common Disaster Benefit]	[All]	[\$500,000]	[U-IMC-]
[Carjacking Benefit]	[All]	[[10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]]	[U-IMC-]
[Felonious Assault Benefit]	[All]	[[15%] of the [Covered Person's] [Policyholder's] Principal Sum]	[U-IMC-]
[Identity Theft Resolution Services]	[All]	[Identity Theft Resolution Services]	[U-IMC-]
[Rehabilitation Benefit]	[All]	[[10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]]	[U-IMC-]
[Seat Belt/[Air Bag] Benefit]	[All]	[Seat Belt - [10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]] [Air Bag - [10%] of the [Covered Person's] [Policyholder's] Principal Sum to a maximum of [\$10,000]]	[U-IMC-]
[]	[All]	[]	[U-IMC-]

X. REPORTING AND NOTICE ADDRESSES:

Claim Reporting:

[Claims Department
Zurich American Insurance Company,
[P.O. Box 968041, Schaumburg, IL. 60196]]
[1-866-841-4771]

SECTION II – ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

[ELIGIBILITY OF DEPENDENTS

When **You** enroll **You** may elect to cover **Your** eligible **Dependents**. An eligible **Dependent** includes **Your Spouse** [or **Domestic Partner**] and **Your Dependent Child(ren)**, [and] [**Your Spouse's Dependent Child(ren)**] [, and **Your Domestic Partner's Dependent Child(ren)**].]

YOUR EFFECTIVE DATE

Your coverage under this **Policy** begins on the Policy Inception Date shown in the Schedule provided:

1. **Your** application is approved by **Us**; and
2. the first premium is received by **Us** in accordance with the **Policy** provisions.

[ELIGIBLE DEPENDENTS EFFECTIVE DATE

An eligible **Dependent'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 **Dependent's** coverage is paid;
3. the date the person qualifies as a **Dependent**;
4. the date on which written enrollment for the **Dependent** is received by **Us**.

Your child born while this **Policy** is in force is covered from the moment of birth for a period of 60 days. An adopted newborn child of an **Insured** is covered from the moment of birth for a period of 60 days. After this time, the child will remain covered only if **You** have provided written notice of birth or the filing of a petition for adoption to **Us** and paid the required premium due, if any.

Your newly adopted child is covered from the moment of adoption or the date of filing of a petition for adoption, for a period of 31 days. After this time, the child will remain covered only if **You** have provided written notice to **Us** of the adoption or the filing of a petition for adoption, and paid the required premium due, if any.

If **You** did not elect coverage for **Your Dependents** at the time of application or from the date of birth or adoption as permitted herein, and wish to add such coverage at a later time, **You** must apply for the additional insurance and pay any additional premium, and the additional person(s) must be added by endorsement. The date on the endorsement will determine when the additional person's coverage 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.

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

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 **Covered Person** is insured under this **Policy**, 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**.

Covered Person means any person who has insurance under the terms of this **Policy**. It includes **You** [and **Your Spouse** [or **Domestic Partner**] and/or **Dependent Child(ren)** if a **Plan** covering **Your Spouse** [or **Domestic Partner**] and/or **Dependent Child(ren)** is selected].

[**Dependent** means **Your Spouse** [or **Domestic Partner**] and **Dependent Child(ren)**, as defined in this section. [**Your Dependent** will only be a covered **Dependent** if a **Plan** covering **Dependents** is selected.]]

[**Dependent Child(ren)** means **Your** unmarried **Child(ren)** and those of **Your Spouse** [or **Domestic Partner**] who rely on **You** for support, and are either: 1) less than 19 (nineteen) years of age; 2) less than 25 (twenty-five) years of age and enrolled on a full-time basis in a college, university, or trade school, or who satisfy neither 1) nor 2), but who prior to his or

her termination of coverage became incapable of self-sustaining employment by reason of mental retardation or physical handicap.]

[Domestic Partner means a person who meets the following requirements:

1. **You** 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. **You** 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. **You** and the **Domestic Partner** must both be at least 18 years of age;
4. neither **You** nor the **Domestic Partner** are legally married;
5. **You** and the **Domestic Partner** are not related by blood or adoption; and
6. **You** and the **Domestic Partner** are each other's sole **Domestic Partner** and intend to remain so indefinitely.

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

1. the **Domestic Partner** being named as the primary beneficiary in the event of **Your** death under **Your** retirement plan or 401(k) plan, if **You** maintain such a plan;
2. at least one of the following:
 - a. designation of the **Domestic Partner** as a primary beneficiary under **Your** will; or
 - b. designation of the **Domestic Partner** as a primary beneficiary for **Your** 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 **Us**.
5. the individual qualifies as a **Domestic Partner** under the law of the state of residence, if applicable.]

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 **You** by blood or marriage.

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

Policy means this Accident Insurance Policy.

Policyholder means the person to whom this **Policy** is issued, as stated in the Schedule.

Principal Sum means the amount of insurance applicable to a **Covered Person** as stated in the Schedule.

Related means **Your Spouse** [or **Domestic Partner**] or other adult living with **You**, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Spouse means **Your** legally married **Spouse** [under age 70].

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

You or **Your** means the **Policyholder**.

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 (sane or insane) 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. Reserve or National Guard active duty training is not excluded, unless it extends beyond thirty-one (31) consecutive days. 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 felony, riot or insurrection.
6. parasailing, bungee jumping, heli-skiing, scuba diving or any other extra-hazardous activity.
7. being intoxicated:
 - a. A **Covered Person** 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 **Covered Person'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 being under the influence of any controlled substance unless administered on the advice of a **Physician**.
13. [any condition for which the **Covered Person** is entitled to benefits under any Workers' Compensation Act, No Fault Auto Coverage or similar law.]

SECTION V – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If a **Covered Person** 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 Benefits. If a **Covered Person** can recover benefits under more than one of the Coverages or Benefits as stated in the Schedule as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

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.
- B. **Grace Period.** Premiums are due for this **Policy** on or before the premium due date or renewal date, whichever applies. If **You** do 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 **Policy** will stay in force.
- 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 **You**. **We** may also change premium at any time when any change, agreed

upon in writing, between **You** 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.

- D. Reinstatement. If this **Policy** lapses due to non-payment of premium, it may be reinstated provided **We** receive from **You** a written application for reinstatement and the required premium payment within one (1) year after the date coverage lapsed. **Your Policy** will be reinstated upon **Our** approval of the application or, lacking such approval, upon the forty-fifth (45th) day following the date of **Our** receipt of premium unless **We** have previously notified **You** in writing of disapproval of the application.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than sixty (60) days before the date of reinstatement.

The reinstated policy will cover loss from a **Covered Injury**. However, the reinstated policy will not cover loss from an injury sustained between the date this **Policy** lapsed and the date it was reinstated.

Changes may be made in this **Policy** in connection with the reinstatement. These changes will be sent to **You** for **You** to attach to this **Policy**. In all other respects, **You** and **We** will have the same rights as before this **Policy** lapsed.

SECTION VII - TERMINATION OF INSURANCE

- A. Policy Renewal and Termination.

Renewal. This **Policy** is guaranteed renewable [until **You** reach age [70]]. **We** cannot change any of the terms of this **Policy**, except that, in the future, **We** may increase the premium **You** pay.

You may terminate this **Policy** at any time by delivering to **Us** a written notice to end this **Policy** effective on receipt or such later date as **You** specify in the notice. **We** will calculate and return the unearned premium, if any, using a standard short rate table. **You** must send **Us** any additional amounts owed, if any, between the **Policy's** paid to date and the official date of termination.

This **Policy** and all insurance for **You** [and **Your Dependents**] will terminate on the earliest of the following:

1. On any premium due date if the payment is not received prior to the end of the Grace Period;
2. On the date **You** reach age [70];
3. On the date of **Your** death;
4. On the date there is fraud or a material misrepresentation made by or with the knowledge of any **Covered Person** in filing a claim for benefits.

- B. [Termination of **Dependent's** Insurance.

All insurance for a **Dependent** will terminate on the earliest of the following:

1. On the date that this **Policy** is terminated;
2. On any premium due date if the premium for that **Dependent** is not received prior to the end of the Grace Period;
3. On the date the **Dependent** reaches age [70];
4. On the first premium due date following the date the person no longer qualifies as a **Dependent**.]

Termination of this **Policy** or of any **Covered Person's** coverage 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. **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within [twenty (20)] days of such **Covered Loss**, or as soon thereafter as reasonably possible. The notice must name the **Covered Person** who sustained the injury and the **Policyholder**. To request a claim form, contact **Us** at [1-866-841-4771.] The notice must be sent to the address shown in 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 and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

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 the **Policyholder**. **Covered Losses** resulting from **Your** 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 **You**, **We** will pay the benefit to **Your** survivors in the following order:
 - a. **Your Spouse** [or **Domestic Partner**];
 - b. **Your** child(ren);
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.
 2. [Loss of Life of a **Covered Person** other than the **Policyholder**. **Covered Losses** for the death of a **Covered Person** other than **You** will be paid to **You**. If **You** predecease or die at the same time as the **Covered Person**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.]
 3. All Other Claims. Benefits are to be paid to **You**. **You** may direct in writing that all, or part of a benefit, if applicable, will be paid directly to the party who furnished the service. The direction may be changed at any time up to the filing of the proof of **Covered Loss**.
 4. Any payment **We** make will fully discharge **Us** to the extent of the payment.

SECTION X - GENERAL POLICY CONDITIONS

- A. Beneficiaries. **You** have 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, **You** may change the beneficiary at any time unless **You** have assigned the interest in this **Policy**. In such case, the person to whom the interest in this **Policy** is assigned 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 approved by one of **Our** executive officers. The approval must be endorsed hereon or attached hereto. 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 any coverage which otherwise would not be in force. If **You** apply for insurance for which **You** are not eligible, **We** will only be liable for any premiums paid to **Us**.
- D. Conformity with Statute. Terms of this **Policy** which, on its effective date, conflict with the statutes of the state, District of Columbia, or territory in which **You** reside on such date are amended to conform to the minimum requirements of such laws.

- E. Entire Contract. This **Policy**, **Your** application, Benefit Riders, and any other attachments represent the entire insurance contract between the **Policyholder** and **Us**.
- F. 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 **Policyholder** 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.
- G. Physical Examination and Autopsy. **We** have the right to examine a **Covered Person** 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 in the event of death unless forbidden by law.
- H. [Reduction Schedule. [At age [70], the **Covered Person's Principal Sum** will be reduced based on the following schedule shown below for the **Covered Person's** attained age:

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

These reductions also apply if:

- 1. the **Covered Person** becomes covered under the **Policy**; or
- 2. the **Covered Person's** coverage increases on or after the date the **Covered Person** attains age [70].]
- I. Time Limit on Certain Defenses. In the absence of fraud, statements made by a **Covered Person** 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 three (3) years from the date coverage starts no such statement (except age) will cause this **Policy** to be contested.
- [J. 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 **Policyholder**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Policyholder** 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 a **Covered Person**.]

SECTION XI – COVERAGE

[ACCIDENTAL DEATH [AND DISMEMBERMENT]] COVERAGE

If [a **Covered Person**] [**You**] [or **Your** covered **Spouse** [or **Domestic Partner**]] [suffer[s] a loss of life as a result of a **Covered Injury**, **We** will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

[If a **Covered Injury** to [a **Covered Person**] [**You**] [or **Your** covered **Spouse** [or **Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	Benefit
1. [Both Hands or Both Feet]	[100% of Principal Sum]]
2. [One Hand and One Foot]	[100% of Principal Sum]]
3. [One Hand or One Foot plus the loss of Sight of One Eye]	[100% of Principal Sum]]

- | | |
|---|----------------------------------|
| 4. [Sight of Both Eyes | [100% of Principal Sum]] |
| 5. [Speech and Hearing | [100% of Principal Sum]] |
| 6. [Speech or Hearing | [50% of Principal Sum]] |
| 7. [One Hand; One Foot; or Sight of One Eye | [50% of Principal Sum]] |
| 8. [Thumb and Index Finger of the same Hand | [25% of Principal Sum]] |
| 9. [Hearing in One Ear | [25% of Principal Sum]] |

For purposes of this coverage:

Covered Loss means:

1. For a foot or hand, actual severance through or above an ankle or wrist joint;
2. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
3. Total and permanent loss of sight;
4. Total and permanent loss of speech; or
5. Total and permanent loss of hearing.]

[EXPOSURE AND DISAPPEARANCE COVERAGE

If [a **Covered Person** is] [You are] exposed to weather because of an **Accident** and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum**, subject to all **Policy** terms.

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

SECTION XII – IMPORTANT NOTICE

The [Insured] [Covered Person] may call [847-605-6000] to present inquiries or to obtain information about coverage or if they need assistance in resolving any complaints. Or, the [Insured] [Covered Person] can write to Zurich American Insurance Company at their administrative office at [1400 American Lane, Schaumburg, IL 60196].

Should the [Insured] [Covered Person] wish to contact the Arkansas Insurance Department for assistance, they may do so by calling [1-800-282-9134]. Or, the [Insured] [Covered Person] may send written correspondence to the Arkansas Insurance Department at [1200 West Third Street, Little Rock, AR 72201-1904].