

SERFF Tracking Number: CATL-126536128 State: Arkansas  
Filing Company: Catlin Insurance Company, Inc. State Tracking Number: 45308  
Company Tracking Number: AHAG 051 (AR) 0110  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Arkansas Group Accident  
Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

## Filing at a Glance

Company: Catlin Insurance Company, Inc.

Product Name: Arkansas Group Accident

TOI: H02G Group Health - Accident Only

Sub-TOI: H02G.000 Health - Accident Only

Filing Type: Form

SERFF Tr Num: CATL-126536128 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 45308

Co Tr Num: AHAG 051 (AR) 0110 State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 04/12/2010

Authors: Carolyn Smart, Darcy  
LeBau

Date Submitted: 03/30/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Arkansas Group Accident

Project Number: AHAG 051 (AR) 0110

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association,  
Trust, Other

Explanation for Other Group Market Type:

Unions & Customers of Financial Institutions

State Status Changed: 04/12/2010

Created By: Darcy LeBau

Corresponding Filing Tracking Number: AHAG  
051 (AR) 0110

Filing Status Changed: 04/12/2010

Deemer Date:

Submitted By: Carolyn Smart

Filing Description:

March 30, 2010 via SERFF

The Honorable Julie Benafield Bowman

Commissioner of Insurance

Arkansas Insurance Department

SERFF Tracking Number: CATL-126536128 State: Arkansas  
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1200 West Third Street

Little Rock, AR 72201

Attention: Life & Health Division

Re: Catlin Insurance Company, Inc.

FEIN#: 204929941

NAIC#: 4574 19518

Arkansas Group Accident Insurance Policy – Form #AHAG 051(AR) 0110  
Arkansas Group Accident Insurance Certificate – Form #AHAG 050(AR) 0110  
Arkansas Group Accident Insurance Enrollment Form – Form #AHAG A01(AR) 0110  
Arkansas Group Application for Group Accident Insurance – Form #AHAG A02(AR) 0110

Honorable Commissioner Benafield Bowman:

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

This is a new group accident product submission. The forms are new and are not intended to replace any other forms currently in use.

Arkansas Group Accident Policy Form #AHAG 051(AR) 0110, provides accident benefits on a Group basis to groups recognized as eligible groups under the laws of your state, including but not limited to employer groups, unions, associations and customers of financial institutions. Optional provisions are chosen by the policyholder at the time of application. Certain wording and benefit amounts reflected in the subject forms is enclosed within brackets ([ ]) and may vary according to a specific plan design. The variable material shown in the policy reflects the benefit levels selected and insured specific information. The variable language or amounts on final printed forms will be no more restrictive than that which is reflected in the enclosed forms and within legal requirements. Please see the enclosed Statement of Variability for Catlin’s explanation of how these forms may vary to accommodate different product offerings.

The Arkansas Certificate of Insurance, Form # AHAG 050(AR) 0110, will be issued to describe the plan benefits when required by law or as requested by the policyholder. When issued, this form will mirror the plan specification as set forth in the policy.

The Group Accident Insurance Enrollment Application, Form #AHAG A01(AR) 0110, will be used for any eligible groups where an individual enrollment is mandated.

The enclosed Application for Group Accident Insurance, Form #AHAG A02(AR) 0110, will detail the benefits applicable to the organization and will be signed by the policyholder.

The enclosed Group Accident Insurance product will be marketed by licensed agents, brokers, and third party administrators to eligible groups.

In accordance with Arkansas’s filing requirements, enclosed please find:

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- Certification of Compliance
- Unfair Sex Discrimination Certificate of Compliance
- Life & Health Guaranty Association Act Notice to Policyholders
- Flesch Certification
- Forms
- Statement of Variables

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

Respectfully,  
Darcy Lebau

## Company and Contact

### Filing Contact Information

Darcy Lebau, Darcy@westmontlaw.com  
Westmont Associates, Inc. 856-216-0220 [Phone]  
25 Chestnut Street, Suite 105  
Haddonfield, NJ 08033

### Filing Company Information

Catlin Insurance Company, Inc. CoCode: 19518 State of Domicile: Texas  
1600 Market Street Group Code: Company Type: Property and  
Casualty  
Suite 1616 Group Name: State ID Number:  
Philadelphia, PA 19103 FEIN Number: 20-4929941  
(215) 466-9132 ext. [Phone]

## Filing Fees

Fee Required? Yes  
Fee Amount: \$300.00  
Retaliatory? Yes  
Fee Explanation: Catlin's domicile state of Texas charges \$50.00 for such a filing. However, Arkansas's fee is higher.  
\$50/form X 5 forms = \$250

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Product Name: Arkansas Group Accident  
Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110  
\$50/rates = \$50  
Total = \$300  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Catlin Insurance Company, Inc.	\$300.00	03/30/2010	35264631

SERFF Tracking Number: CATL-126536128 State: Arkansas  
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 Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/12/2010	04/12/2010

### 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	04/02/2010	04/02/2010	Carolyn Smart	04/09/2010	04/09/2010

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## Disposition

Disposition Date: 04/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Catlin Insurance Company, Inc.	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Supporting Document	Arkansas Consumer Information Notice	Approved-Closed	Yes
Supporting Document	Reply Letter	Approved-Closed	Yes
Form (revised)	Arkansas Catlin Group Accident Policy	Approved-Closed	Yes
Form	Arkansas Catlin Group Accident Policy	Replaced	Yes
Form (revised)	Arkansas Catlin Group Accident Certificate	Approved-Closed	Yes
Form	Arkansas Catlin Group Accident Certificate	Replaced	Yes
Form	Arkansas Catlin Group Accident Application	Approved-Closed	Yes
Form (revised)	Arkansas Catlin Group Accident Enrollment Form	Approved-Closed	Yes
Form	Arkansas Catlin Group Accident Enrollment Form	Replaced	Yes
Form	Arkansas Guaranty Association Notice	Approved-Closed	Yes
Rate	Arkansas Group Accident Actuarial Memorandum	Approved-Closed	No

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/02/2010  
Submitted Date 04/02/2010

Respond By Date  
Dear Darcy Lebau,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Arkansas Catlin Group Accident Policy, AHAG 051 (AR) 0110 (Form)
- Arkansas Catlin Group Accident Certificate, AHAG 050 (AR) 0110 (Form)

Comment: With respect to exclusions for Terrorism or Terrorism Acts, this is to advise that our Department is not approving Terrorism or Terrorism type exclusions. It is requested that these exclusions be deleted.

### Objection 2

- Arkansas Catlin Group Accident Enrollment Form, AHAG A01 (AR) 0110 (Form)

Comment:

This enrollment form must contain a Fraud Statement as outlined under ACA 23-66-503.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 04/09/2010  
Submitted Date 04/09/2010

Dear Rosalind Minor,

### Comments:

Good afternoon Ms. Minor,

By Letter dated 4/1/2010, the Arkansas DOI objected to the above referenced filing. A copy of the Objection Letter is attached. This Memorandum will identify the revisions Catlin Insurance Company, Inc. made in response to your objections.

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 Product Name: Arkansas Group Accident  
 Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

**Response 1**

Comments: Please see attached Reply Letter and revised forms.

**Related Objection 1**

Applies To:

- Arkansas Catlin Group Accident Policy, AHAG 051 (AR) 0110 (Form)
- Arkansas Catlin Group Accident Certificate, AHAG 050 (AR) 0110 (Form)

Comment:

With respect to exclusions for Terrorism or Terrorism Acts, this is to advise that our Department is not approving Terrorism or Terrorism type exclusions. It is requested that these exclusions be deleted.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Reply Letter

Comment: Reply Letter is attached.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Arkansas Catlin Group Accident Policy	AHAG 051 (AR) 0110		Policy/Contract/Fraternal Certificate	Initial		52.200	AR CATLIN POLICY FINAL CLEAN response 040910.pdf

**Previous Version**

Arkansas Catlin Group Accident Policy	AHAG 051 (AR) 0110		Policy/Contract/Fraternal Certificate	Initial		52.200	AR CATLIN POLICY FINAL CLEAN.pdf
Arkansas Catlin Group	AHAG 050		Certificate	Initial		52.200	AR

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 Product Name: Arkansas Group Accident  
 Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110  
 Accident Certificate (AR) 0110

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**Previous Version**

Arkansas Catlin Group	AHAG 050	Certificate	Initial	52.200	AR
Accident Certificate	(AR) 0110				CATLIN CERTIFIC ATE FINAL CLEAN.pd f

No Rate/Rule Schedule items changed.

**Response 2**

Comments: Please see attached Reply Letter and revised forms.

**Related Objection 1**

Applies To:

- Arkansas Catlin Group Accident Enrollment Form, AHAG A01 (AR) 0110 (Form)

Comment:

This enrollment form must contain a Fraud Statement as outlined under ACA 23-66-503.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Reply Letter

Comment: Reply Letter is attached.

**Form Schedule Item Changes**

*SERFF Tracking Number:* CATL-126536128      *State:* Arkansas  
*Filing Company:* Catlin Insurance Company, Inc.      *State Tracking Number:* 45308  
*Company Tracking Number:* AHAG 051 (AR) 0110  
*TOI:* H02G Group Health - Accident Only      *Sub-TOI:* H02G.000 Health - Accident Only  
*Product Name:* Arkansas Group Accident  
*Project Name/Number:* Arkansas Group Accident/AHAG 051 (AR) 0110

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Arkansas Catlin Group Accident Enrollment Form	AHAG A01 (AR) 0110		Application/Enrollment Form	Initial		52.200	AR CATLIN ENR FORM FINAL CLEAN response 040910.pdf

**Previous Version**

Arkansas Catlin Group Accident Enrollment Form	AHAG A01 (AR) 0110		Application/Enrollment Form	Initial		52.200	AR CATLIN ENR FORM FINAL CLEAN.pdf
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No Rate/Rule Schedule items changed.

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

Respectfully,  
Darcy Lebau

Sincerely,  
Carolyn Smart, Darcy LeBau

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## Form Schedule

### Lead Form Number: AHAG 051 (AR) 0110

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/12/2010	AHAG 051 (AR) 0110	Policy/Contractual Certificate	Arkansas Catlin Group Accident Policy	Initial		52.200	AR CATLIN POLICY FINAL CLEAN response 040910.pdf
Approved-Closed 04/12/2010	AHAG 050 (AR) 0110	Certificate	Arkansas Catlin Group Accident Certificate	Initial		52.200	AR CATLIN CERTIFICATE FINAL CLEAN response 040910.pdf
Approved-Closed 04/12/2010	AHAG A02 (AR) 0110	Application/Enrollment Form	Arkansas Catlin Group Accident Application	Initial		52.200	AR CATLIN APPLICATION FINAL CLEAN.pdf
Approved-Closed 04/12/2010	AHAG A01 (AR) 0110	Application/Enrollment Form	Arkansas Catlin Group Accident Enrollment Form	Initial		52.200	AR CATLIN ENR FORM FINAL CLEAN response 040910.pdf
Approved-Closed 04/12/2010	PNAP 038 0310	Other	Arkansas Guaranty Association Notice	Initial			Arkansas Guaranty Association Notice.pdf

**Catlin Insurance Company, Inc.**  
**Statutory Home Office: 1330 Post Oak Boulevard, Suite**  
**2325, Houston, TX 77056**  
**Administrative Office: 3340 Peachtree Road N.E., Suite**  
**2950, Atlanta, GA 30326**  
**A Stock Insurance Company**

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**ARKANSAS GROUP ACCIDENT POLICY**

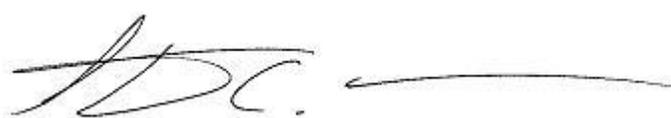
**POLICYHOLDER:** {ABC Company, Inc.}  
**POLICY NUMBER:** {Specimen}  
**POLICY EFFECTIVE DATE:** {January 1, 2008}  
**POLICY ANNIVERSARY DATE:** {January 1}  
**STATE OF ISSUE:** {Any State}

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 AM on the Policy Effective Date shown above at the Policyholder's address. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

**THIS IS A GROUP ACCIDENT ONLY INSURANCE POLICY.**  
**IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.**

**THIS IS A LIMITED POLICY.**  
**PLEASE READ IT CAREFULLY.**



Secretary



President

Countersigned \_\_\_\_\_

Where Required By Law

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## **[SCHEDULE OF COVERED AFFILIATES**

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The following affiliates are covered under this Policy on the effective dates listed below.

AFFILIATE NAME	LOCATION	EFFECTIVE DATE
{ABC Company}	{ city, state}	{January 1, 2001}}

## SCHEDULE OF BENEFITS

***This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.***

**The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the *Description of Coverages and Benefits* Section for full details.**

<b>Effective Date Policyholder:</b>	
-------------------------------------	--

<b>[Minimum Participation Requirements</b>	Percentage {0% - 100% of eligible [Employees] [Members]}
--	--

### **[Covered Classes**

Class 1	All full-time Employees of the Policyholder working at least [20-40] hours per week.
Class 2	All part-time Employees working at least [0-40] hours per week.
Class 3	All active Members of the Policyholder.
Class 4	All Spouses and Dependent Children of Class 1, 2, or 3. ]

### **[Eligibility Waiting Period**

The Eligibility Waiting Period is the period of time the [Employee] [Member] must be in a Covered Class to be eligible for coverage. [It will be extended by the number of days the [Employee] [Member] is absent from scheduled work.]

For [Employees] [Members] added [{31 days} or more] before the Policy Effective Date:	{No Waiting Period}
For [Employees] [Members] added [less than {31 days} before, or] after the Policy Effective Date:	{One month; 30 days; 31 days]}

### **[Time Period for Loss**

[Any Covered Loss must occur within:	{90 - 365 days} of the Covered Accident]}
--------------------------------------	---

**This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Covered Person's] Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.**

### **[ACCIDENTAL DEATH BENEFIT**

[[Employee] [Member] Principal Sum:	{\$0 - \$2,000,000 in increments of \$500]}
[Spouse Principal Sum:	{\$0 - \$2,000,000 in increments of \$500]}
[Dependent Child(ren) Principal Sum:	{\$0 - \$1,000,000]}

### **[Age Reductions**

A Covered Person's Principal Sum will be reduced by the percentage shown below:

<b>Age</b>	<b>Percentage of Benefit Amount</b>
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member].]

**[Aggregate Limit of Liability]**

Each Covered {Aircraft} Accident	{\$0 - \$5,000,000 for all Covered Persons}
Applies to:	{Accidental Death and Dismemberment Benefits or Accidental Death Benefits or All coverage and benefits provided by this Policy}

If this aggregate amount does not allow all Covered Persons to be paid the amounts the specified benefits otherwise provide, the amount paid for each Covered Person is the proportion each Loss bears to the Aggregate Limit of Liability. [Covered Aircraft Accident means a Covered Accident involving a scheduled or chartered flight in an Aircraft.]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS]**

[[Employee] [Member] Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}
[Spouse Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}
[Dependent Child(ren) Principal Sum:	{\$0 - \$1,000,000}

**SCHEDULE OF COVERED LOSSES**

<b>Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{100% of the Principal Sum}}
[Loss of Two or More Hands or Feet	{100% of the Principal Sum}}
[Loss of Sight of Both Eyes	{100% of the Principal Sum}}
[Loss of Speech and Hearing (in both ears)	{100% of the Principal Sum}}
[Loss of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Sight in One Eye	{50% of the Principal Sum}}
[Severance and Reattachment of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Speech	{50% of the Principal Sum}}
[Loss of Hearing (in both ears)	{50% of the Principal Sum}}
[Loss of Thumb and Index Finger of the Same Hand	{25% of the Principal Sum}}
[Loss of all Four Fingers of the Same Hand	{25% of the Principal Sum}}
[Loss of all the Toes of the Same Foot	{20% of the Principal Sum}}

**[Age Reductions]**

A Covered Person's Principal Sum will be reduced by the percentage shown below:

<b>Age</b>	<b>Percentage of Benefit Amount</b>
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member].]

**[ADDITIONAL ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGES]**

[[Accidental Death and Dismemberment} benefits are provided under the following coverage. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.]

<b>[ARMED FORCES COVERAGE]</b>	Principal Sum multiplied by the percentage
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	applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[EXPOSURE AND DISAPPEARANCE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[OWNED AIRCRAFT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[PILOT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[WAR RISK COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]

**[ADDITIONAL ACCIDENT BENEFITS ]**

[Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other {Accidental Death and Dismemberment benefits} payable.]

<b>[ADDITIONAL OCCUPATIONAL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT</b>	
Benefit Amount	{\$75 per session}
Maximum Number of Sessions	{10 sessions}
Maximum Benefit Per Covered Accident	[\$750]

<b>[BOMB SCARE, BOMB SEARCH, OR BOMB EXPLOSION BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[BULLETPROOF VEST BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[BURIAL AND CREMATION BENEFIT</b>	[\$0 - \$5,000]
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<b>[BUSINESS TRAVEL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[CHILD CARE CENTER BENEFIT</b>	
Benefit Amount	[\$0 - \$3,000 per year}
Maximum Benefit Period	{to Age {13} for each surviving Dependent Child}]

<b>[COMMON CARRIER BENEFIT</b>	{50%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the
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<i>Schedule of Covered Losses</i>	
<b>[Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{\$10,000}}
[Loss of Two or More Hands or Feet	{\$10,000}}
[Quadriplegia	{\$10,000}}
[Hemiplegia	{\$5,000}}
[Uniplegia	{\$5,000}}
[Coma	{\$5,000}}]]

<b>[EMERGENCY ROOM BENEFIT</b>	
Benefit Amount	{\$200}
Maximum Payable Visits per Calendar Year	{5}
Maximum Benefit Per Covered Accident	{\$1,000}}

<b>[ESCALATOR BENEFIT</b>	
Periodic Increase	{10% of the Principal Sum}
Frequency of Increases	{Annually}
Maximum Total Increase	{50% of the Principal Sum}}

<b>[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT</b>	
Accidental Death and Dismemberment Benefit	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .
Hospital Stay Benefit	{\$100 per day}
Maximum Benefit Period	{730 days per Hospital Stay per Covered Accident}}

<b>[HIV OCCUPATIONAL ACCIDENT BENEFIT</b>	
	{25%} of the Principal Sum [subject to a maximum of {\$100,000}]]

<b>[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT</b>	
Benefit	{10% of the Principal Sum subject to a maximum of \$25,000}}

<b>[HOSPITAL STAY BENEFIT</b>	
Benefit Amount	{\$200 per day}
Maximum Benefit Period	{730 days per Hospital Stay per Covered Accident}
Benefit Waiting Period	{7 days}}

<b>[PRIVATE PASSENGER BENEFIT</b>	
{30% of the Principal Sum} <i>not applicable if stand-alone benefit</i>	
<b>[Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{\$10,000}}
[Loss of Two or More Hands or Feet	{\$10,000}}
[Quadriplegia	{\$10,000}}
[Hemiplegia	{\$5,000}}
[Uniplegia	{\$5,000}}
[Coma	{\$5,000}}]]

<b>[REHABILITATION BENEFIT</b>	
Benefit per Covered Accident	{10% of the Principal sum, subject to a maximum of

	\$250,000}]
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<b>[SEATBELT [AND AIRBAG] BENEFIT</b>	
[Seatbelt Benefit	{10%} of the Principal Sum [subject to a Maximum Benefit of {\$25,000}]
[Airbag Benefit	{5%} of the Principal Sum [subject to a Maximum Benefit of {\$25,000}]
[Default Benefit	{\$1,000}]

<b>[SPECIAL EDUCATION BENEFIT</b>	
Surviving Dependent Child Benefit	{5%} of the Principal Sum [subject to a Maximum Benefit of {\$7,500}]
[Surviving Spouse Benefit	{5%} of the Principal Sum [subject to a Maximum Benefit of {\$7,500}]
Maximum Number of Annual Payments	
[For Each Surviving Dependent Child	{4}]
[For Surviving Spouse	{4}]
Default Benefit	{\$1,000}]

<b>[TOTAL DISABILITY WEEKLY INCOME BENEFIT</b>	
Weekly Benefit Amount	{\$500}
Benefit Waiting Period	{7 days}
Maximum Benefit Period per Covered Accident	{26 weeks}]

<b>[WAIVER OF PREMIUM BENEFIT</b>	
Benefit Waiting Period	{9 months}
Benefit Period	
<u>Age when Total Disability Begins</u>	<u>Benefit Period</u>
Less than 60	{to 65 <sup>th</sup> birthday}
60 and later	{60 months}]

**[INITIAL PREMIUM RATES**

Premium Rate:	{Premium amounts will vary based on the plan of benefits: \$123.45} per {covered [Employee] [Member], covered [Employee] [Member] and covered Spouse, per Dependent Child, per month}
Mode of Premium Payment:	{Monthly; Quarterly; Semi-Annually; Annually}
Contributions:	The cost of coverage is paid by the {Policyholder; Policyholder and Covered Person}
Premium Due Dates:	The Policy Effective Date and the first day of each succeeding {interval}[month].

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of this Policy. [Each Covered Person's premiums are based on his Age and will increase on the next premium due date after the Covered Person enters a new Age bracket.]]

## GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

<b>[Active Service]</b>	<p>[An [Employee] [Member] will be considered in Active Service with the Policyholder on any day that is either of the following:</p> <ol style="list-style-type: none"> <li>1. [one of the Policyholder's scheduled work days on which the [Employee] [Member] is performing his regular duties on a full-time basis, either at one of the Policyholder's usual places of business or at some other location to which the Policyholder's business requires the [Employee] [Member] to travel; or]</li> <li>2. [a scheduled holiday; vacation day; or period of approved paid leave of absence; other than sick leave, only if the [Employee] [Member] was in Active Service on the Preceding scheduled workday; or]</li> <li>3. [a day on which the Member meets all the conditions of membership of the Policyholder.]]</li> </ol> <p>[An eligible Dependent Child or eligible Spouse of the [Employee] [Member] is considered in Active Service if he is none of the following:</p> <ol style="list-style-type: none"> <li>1. an Inpatient in a Hospital; or receiving Outpatient care for chemotherapy or radiation therapy;</li> <li>2. Confined at home under the care of Physician for Sickness or Injury;</li> <li>3. Totally Disabled.]]</li> </ol>
<b>[Age]</b>	<p>A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. {Thereafter, it is his Age attained on: [the last Policy anniversary;] or [his last birthday.]]}</p>
<b>[Aircraft]</b>	<p>A vehicle which:</p> <ol style="list-style-type: none"> <li>1. has a valid certificate of airworthiness; and</li> <li>2. is being flown by a pilot with a valid license to operate the Aircraft.]]</li> </ol>
<b>[Certificate]</b>	<p>The Certificate is not the Policy and is evidence of the Employee/Member's coverage under the Policy. Coverage is subject to the Policy provisions.]]</p>
<b>Complications of Pregnancy</b>	<p>Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; but does not include false labor; pre-term or premature labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning Sickness; hyperemesis gravidarum; pre-eclampsia; and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Also included is: a non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy; occurring during a period of gestation in which a viable birth is not possible.</p>
<b>[Core Plan]</b>	<p>The noncontributory plan of benefits provided under this Policy.]]</p>
<b>Covered Accident</b>	<p>A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:</p>

	<ol style="list-style-type: none"> <li>1. occurs while the Covered Person is insured under this Policy;</li> <li>2. is not contributed to by disease, Sickness, mental or bodily infirmity;</li> <li>3. [occurs while the Covered Person is { attending}{, participating in,} {or traveling to and from} any event sponsored by the Policyholder;</li> <li>4. is not otherwise excluded under the terms of this Policy.</li> </ol>
<b>[Covered Injury</b>	Any bodily harm that results directly and independently of all other causes from a Covered Accident.]
<b>[Covered Loss</b>	<p>A loss that is all of the following:</p> <ol style="list-style-type: none"> <li>1. the result, directly and independently of all other causes, of a Covered Accident;</li> <li>2. one of the Covered Losses specified in the Schedule of Covered Losses;</li> <li>3. suffered by the Covered Person within the applicable time period specified in the <i>Schedule of Benefits</i>.]</li> </ol>
<b>Covered Person</b>	An eligible person, as defined in the Schedule of Benefits, for whom [an enrollment form has been accepted by Us and] required premium has been paid when due and for whom coverage under this Policy remains in force. [The term Covered Person shall include, where this Policy provides coverage, an eligible Spouse and eligible Dependent Children.]
<b>[Dependent Child(ren)</b>	<p>An [Employee's] [Member's] unmarried child who meets the following requirements:</p> <ol style="list-style-type: none"> <li>1. A child from live birth to {19} years old;</li> <li>2. A child who is {19} or more years old but less than {23} years old, enrolled in a school [as a full-time student] and primarily supported by the [Employee] [Member];</li> <li>3. A child who is {19} or more years old, chiefly dependent on the [Employee] [Member] for support and maintenance and incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapable prior to his 19<sup>th</sup> birthday. Notice of the child's condition and dependence must be submitted to Us. If the incapacity or dependency is later removed or terminated, the [Employee] [Member] must notify Us of the change. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.</li> </ol> <p>A child, for purposes of this provision, includes an [Employee's] [Member's]:</p> <ol style="list-style-type: none"> <li>1. natural child;</li> <li>2. child under the charge, care, and control of the [Employee] [Member] whom the [Employee] [Member] has filed a petition to adopt, until the dismissal or denial of the petition for adoption;</li> <li>3. stepchild [who resides with the [Employee] [Member]], [unless group term life insurance is provided by a non-custodial parent pursuant to a Qualified Domestic Relations Order];</li> <li>4. [child for whom the [Employee] [Member] is legal guardian.]</li> </ol> <p>[If an [Employee] [Member] who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with the [Employee] [Member] for at least [six consecutive months] and intend to reside with the [Employee] [Member] for an indefinite period of time.]]</p>

<b>[Domestic Partners]</b>	<p>A person of the same or opposite sex who:</p> <ol style="list-style-type: none"> <li>1. shares the covered [Employee's] [Member's] permanent residence;</li> <li>2. has resided with the covered [Employee] [Member] continuously for at least {six months - two years} and is expected to reside with the covered [Employee] [Member] indefinitely;</li> <li>3. Is financially interdependent with the covered [Employee] [Member] in each of the following ways: <ol style="list-style-type: none"> <li>[a. by holding one or more credit or bank accounts, including a checking account, as joint owners;]</li> <li>[b. by owning or leasing their permanent residence as joint tenants;]</li> <li>[c. by naming, or being named by, the covered [Employee] [Member] as a beneficiary of life insurance or under a will;]</li> <li>[d. by each agreeing in writing to assume financial responsibility for the welfare of the other;]</li> </ol> </li> <li>4. has signed a Domestic Partner declaration with the covered [Employee] [Member], if the covered [Employee] [Member] resides in a jurisdiction which provides for a Domestic Partner declaration;]</li> <li>5. has not signed a Domestic Partner declaration with any other person within the last {12 - 24 months;}</li> <li>6. is no less than {18 - 23} years not more than {60 - 70} years of age;</li> <li>7. is not legally permitted to marry the covered [Employee] [Member];]</li> <li>8. is not legally married to any other person;</li> <li>9. is not a blood relative any closer than would prohibit legal marriage.</li> </ol> <p>[In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.]</p> <p>A covered [Employee] [Member] may insure a Domestic Partner if all of the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. the covered [Employee] [Member] has not been married to any person within the past {12 - 24} months;</li> <li>2. the Domestic Partner is the only person meeting this Policy's definition of "Domestic Partner" with respect to the covered [Employee] [Member];</li> <li>3. The covered [Employee] [Member] and the Domestic Partner furnish a notarized affidavit/signed statement reflecting these requirements, and an agreement to notify Us if the requirements cease to be met, on a form acceptable to Us.]]</li> </ol>
<b>[Effective Date]</b>	The date on which insurance under the Policy begins as shown in the Schedule of Benefits.]
<b>[Emergency Room Treatment]</b>	Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in deterioration to the point of placing a Covered Person's life in jeopardy or cause serious impairment to bodily functions.]]
<b>[Employee]</b>	For eligibility purposes, an Employee of the Policyholder who is in one of the Covered Classes. [The term does not include Employees who work less than {20 - 30 hours per week} for the Policyholder.]]
<b>[Employer]</b>	The Policyholder and any affiliates, subsidiaries or divisions shown in the <i>Schedule of Covered Affiliates</i> and which are covered under this Policy on the date of issue or subsequently agreed to by Us.]

<b>[He, His, Him</b>	Refers to any individual, male or female.]
<b>[Hospital</b>	<p>An institution that meets all of the following:</p> <ol style="list-style-type: none"> <li>1. it is licensed as a Hospital pursuant to applicable law;</li> <li>2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;</li> <li>3. it is managed under the supervision of a staff of medical doctors;</li> <li>4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);</li> <li>5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;</li> <li>6. it charges for its services.</li> </ol> <p>[Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.]</p> <p>The term Hospital does not include a clinic, facility, or unit of a Hospital for:</p> <ol style="list-style-type: none"> <li>1. rehabilitation, convalescent, custodial, educational or nursing care;</li> <li>2. the aged, drug addicts or alcoholics;</li> <li>3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.]]</li> </ol>
<b>[Hospital Stay</b>	A confinement in a Hospital, ordered by a Physician, over a period of time when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least { 90 days - 180 days}.]
<b>[Inpatient</b>	A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.]
<b>[Insured</b>	A person: (1) who is a member of an eligible class of person as described in the Schedule of Benefits; (2) for whom premium has been paid; and (3) while covered under this Policy.]
<b>[Member</b>	<p>For eligibility purposes, a Member is any one of the following:</p> <ol style="list-style-type: none"> <li>[1. an Employee of the Policyholder, [not including a temporary or seasonal Employee];]</li> <li>[2. an Employee of a Member in good standing of a Policyholder [, not including a temporary or seasonal employee];]</li> <li>[3. a person who meets all of the conditions of membership of a Policyholder];</li> </ol> <p>[and who is [Optional, a United States citizen or has a permanent alien registration card and who is] in one of the Covered Classes.]]</p>
<b>[Nurse</b>	<p>A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not:</p> <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household; or</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>

<b>[Outpatient</b>	A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.]
<b>[Physical Therapist</b>	Any practitioner of physical therapy who is duly licensed in the state where he is practicing and who is practicing within the scope and limitations of that license.]
<b>[Physician</b>	A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household;</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>
<b>[Permanent Total Disability</b>	[An Employee][A Member][A Spouse] who is Totally Disabled and is expected to remain Totally Disabled, as certified by a Physician, for the rest of his life.
<b>[Policy</b>	A legal contract between the Policyholder and the Company which describes the terms and conditions of insurance subject to its provisions, limitations and exclusions.]
<b>[Prior Plan</b>	The plan of insurance, {former plan number, former insurance company name} providing similar benefits, sponsored by the Policyholder in effect immediately prior to this Policy's Effective Date.]
<b>[Rehabilitation Facility</b>	A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which: <ol style="list-style-type: none"> <li>1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation Inpatient care;</li> <li>2. is duly licensed by the appropriate government agency to provide such services; and</li> <li>3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission of Accreditation of Rehabilitation Facilities.</li> </ol> <p>A Rehabilitation Facility does not include institutions which provide only: minimal care; custodial care; care for the terminally ill; part-time care; or services or facilities for drug abuse or alcoholism.]</p>
<b>[Related Stays</b>	Successive stays in a Hospital unless: <ol style="list-style-type: none"> <li>1. any stay after the first is necessitated by causes entirely unrelated to the causes of the earlier stay; or</li> <li>2. the stays are separated by at least {180 days}.]</li> </ol>
<b>[Schedule of Benefits</b>	A brief outline of the coverage and benefits provided by this Policy.]
<b>[Sickness</b>	A physical or mental illness [including pregnancy]. Complications of pregnancy are considered a Sickness.]
<b>[Spouse[*</b>  <b>*The term Spouse includes a Domestic Partner as defined.]</b>	The [Employee's] [Member's] lawful spouse [who is aged {18 – under age 70.} [who is a United States citizen or has a permanent Alien Registration Card.] [Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed by {or divorced or legally separated from} an [Employee] [Member].]]

<b>[Termination Date</b>	The date on which insurance ends as defined later in this Policy.]
<b>[Totally Disabled or Total Disability</b>	<p>Totally Disabled or Total Disability means [either]:</p> <ol style="list-style-type: none"> <li>1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of: education; training; or experience; [or]</li> <li>2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including: eating; transferring; dressing; toileting; bathing; and continence; without human supervision or assistance.]</li> </ol>
<b>[We, Us, Our</b>	Catlin Insurance Company, Inc.]

## **ELIGIBILITY AND EFFECTIVE DATE PROVISIONS**

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### **[Policy Effective Date**

The Insurance Company agrees to provide Accident Insurance Benefits described in this Policy in consideration of: the Policyholder's application; and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page [as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied].]

### **Eligibility**

[An Employee] [A Member] becomes eligible for insurance under this Policy on the date: he meets all of the requirements of one of the Covered Classes; and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* [and is insured under the Core Plan]. [A Spouse and Dependent Children of an eligible [Employee] [Member] become eligible for any dependent insurance provided by this Policy on the later of: the date the [Employee] [Member] becomes eligible; and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of this Policy.] [No person may be eligible for insurance under this Policy as both [an Employee] [a Member] and a Spouse or Dependent Child at the same time.]

[An Employee] [A Member] whose eligible class is changed after the Effective Date of his coverage shall become eligible under the new eligible class on the [first day of the month coinciding with or next following] the date of the change.

[The [Employee] [Member] Eligibility Waiting Period may differ for current and newly covered persons. ]

### **[Effective Date for Individuals**

Insurance becomes effective for an eligible [Employee] [Member] [who applies: within {31 days} of the date he becomes eligible; [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under this Policy;
2. [the date][the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date][the first of the month after] We receive the [Employee's] [Member's] completed enrollment form during his lifetime.]

[We may, from time to time, require the [Employee] [Member] to re-enroll using forms supplied by Us to keep his insurance in force.}]

[Insurance becomes effective for an [Employee's] [Member's] eligible Dependent Children [if the [Employee] [Member] applies: within {31 days} of the date his Dependent Children become eligible;] [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of Policyholder under this Policy;
2. [the date][the first of the month after] the [Employee] [Member] becomes eligible;]
3. [the date][the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
4. [the date] [the first of the month after] the Spouse or Dependent Child meets the definition of Spouse or Dependent Child, as applicable;]
5. [the date] [the first of the month after] We receive the [Employee's] [Member's] completed enrollment form for Spouse and Dependent Child coverage, during each Spouse or Dependent Child's lifetime.]

[Insurance becomes effective for an eligible [Employee] [Member] who applies and agrees to make required contributions: within {31 days} of eligibility;] [and subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under this Policy;
2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date] [the first of the month after] We receive the [Employee's] [Member's] completed enrollment form and the required first premium, during his lifetime.]]

[Insurance becomes effective for an [Employee's] [Member's] eligible Dependent Children if the [Employee] [Member] applies and agrees to make required contributions within {31 days} of the date his Dependent Children become eligible [and, subject to the *Deferred Effective Date* provision below], on the latest of the following dates:

1. the effective date of Policyholder under this Policy;
2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;]
3. [the date] [the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
- 4.] [the date] [the first of the month after] the Spouse or Dependent Child meets the definition of Spouse or Dependent Child, as applicable;
- 5.] [the date] [the first of the month after] We receive a completed enrollment form for Spouse and Dependent Child coverage and the required first premium, during each Dependent Child's lifetime.]

**Newborn Children:** [An Employee's] [A Member's] newborn child is automatically covered from the moment of birth until such child is 90 days old if all other eligible children are covered under the certificate prior to the birth of the newborn child. Coverage for newborns shall be the same as for all other covered Dependent Children. The [Employee] [Member] must notify the Company in writing within 90 days of such birth or before the next premium due date, whichever is later, and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

**Adopted Children:** An adopted child is automatically covered for the first 60 days from the date of the [Employee] [Member] filing a petition for adoption unless the petition is denied or dismissed. Coverage for such child will be the same as for all other covered Dependent Children. The [Employee] [Member] must: notify the Company in writing within 60 days of: filing the petition for adoption; and pay the required additional premium (if any); in order to have coverage for the adopted child continue beyond such 60 day period.

#### **[DEFERRED EFFECTIVE DATE**

##### **[Active Service**

The effective date of insurance will be deferred for any [Employee] [Member] [or any eligible Spouse or Dependent Child] who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of: the date he returns to Active Service; and the date coverage would otherwise have become effective.]

##### **[Late Enrollment**

If application for insurance is not made within {31 days} of the date a person is first eligible for coverage [or a Life Status Change] [or during an Annual Re-Enrollment], the Covered Person will be considered a late enrollee. Coverage for any late enrollee will become effective on the later of: the date We approve the required evidence of insurability and receive required premium; and the date coverage would otherwise have become effective.]

##### **[Replacement Coverage**

[An Employee] [A Member] [and any Spouse and Dependent Children] who were insured under a Prior Plan and who is a member of the class of individuals eligible for coverage under this Policy on the effective date of the Policyholder under this Policy will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; and
2. the amount of coverage provided under this Policy.

If the amount of coverage otherwise provided by this Policy is greater than the amount provided under the Prior Plan, the greater amount will become effective on the {first day of the month on or after, or first day of the Policy year on or after or date] the [Employee] [Member], [Spouse or Dependent Child] returns to Active Service.]

[If [an Employee] [a Member] is required to contribute to the cost of any portion of his [or his Dependent Children's] insurance and is not in Active Service on the effective date of the Policyholder under this Policy, coverage will terminate {31 days} after the [Employee] [Member] returns to Active Service unless he submits an enrollment form and the required initial premium. If the [Employee] [Member] selects the amount of benefit for which he is required to pay premium for himself [or any Dependent Children], the amount in effect under this provision will be the lesser of: the amount provided under the Prior Plan; and the smallest amount he may select under this Policy.]

### **[Annual Re-Enrollment**

[An Employee] [A Member] currently insured under {the voluntary Accident portion of} this Policy, and a person who is eligible but has not previously enrolled, may increase or become insured for coverage under this Policy during an annual re-enrollment period as agreed to by Us and the Policyholder. [An Employee] [A Member] who is insured under this Policy may also elect or increase coverage for his eligible Dependent Children.] Coverage elected during an Annual Re-Enrollment Period will become effective [, subject to the *Active Service* section of the *Deferred Effective Date* provision,] on [the Policy Anniversary following, or first day of the month following the] date We receive a request and any required premium payment.]

### **[Life Status Change**

A Life Status Change an event that the Policyholder determines qualifies [an Employee] [a Member] to [elect,] or increase accident insurance benefits [for himself and his Spouse and Dependent Children]. [Any change in benefit elections must be made within {31 days} of a Life Status Change.]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase his accident insurance include:

- [1. marriage];
- [2. loss of a spouse, whether by death, divorce, annulment or legal separation];
- [3. birth or adoption of a child, or acquiring a child through marriage]; and
- [4. an increase in cost or a significant reduction or loss of group accident benefits provided by a Spouse's Plan].]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase accident insurance for his Spouse and eligible Dependent Children include:

- [1. marriage];
- [2. birth or adoption of a child, or acquiring a child through marriage]; and
- [3. a significant reduction, increase in cost or loss of group accident benefits provided by a Spouse's Plan].]

Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the [{first of the month following the} Life Status Change [or the {first day of the month following the} date the [Employee] [Member] applies and agrees to make required contributions]].

[The Policyholder should seek advice of its tax advisors if [Employees] [Members] may contribute to the cost of any insurance provided by this Policy with earnings not subject to Federal Income Tax. We cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward cost of insurance.]]

### **Effective Date of Changes**

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the [Employee's] [Member's] Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

### **TERMINATION OF INSURANCE**

The insurance on a Covered Person will end on the earliest date below:

1. the date this Policy or insurance for a Covered Class is terminated;
- [2. the date the Policyholder's coverage under this Policy ends;]
3. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
4. the last day of the last period for which premium is paid;
- [5. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy, as shown in the *Schedule of Benefits*;]
- [6. with respect to a Spouse {or Dependent Child}, the date of the death of the covered [Employee] [Member] [or the date of divorce from the covered [Employee] [Member], unless the Spouse elects to continue insurance, including insurance on Dependent Children.] See *Continuation of Insurance* section;]
- [7. the date that the plan of benefits under which the Covered Person is covered is terminated.]

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

#### **[CONTINUATION OF INSURANCE**

Insurance for the covered Spouse [and Dependent Children] may be continued if a covered Spouse's [and Dependent Children's] insurance would otherwise end because of death of or divorce from the covered [Employee] [Member]. The Covered Spouse must:

1. submit a written request for continued insurance to Us within {31, 60, 90 days} of the event; and
2. pay the required premium to the Policyholder directly to Us.]

[Insurance continued under this provision may not exceed the amount of insurance in force on the day before insurance as a covered Spouse ended, nor may a Spouse add any Dependent Children for insurance.]

Premiums for insurance continued under this provision will start with: the Premium Due Date on; or next following the date of the event. If a Spouse does not: elect to continue insurance under this provision; or does not provide notification within the required time period; insurance will not be continued and any premium paid from the date of the event will be refunded. [However, if notification is not given to Us within the time period required in (1.) above, any return of premium will be limited to any excess paid in the last {six, 12 months}]

Any Continuation of Insurance is subject to Our continuing to offer insurance under this Policy to new applicants.]

#### **[CONTINUATION OF INSURANCE**

We will continue insurance under this Policy for a Spouse [and Dependent Children] of a covered [Employee] [Member] who dies, without payment of premium for {12 to 24 months}. The Spouse [and Dependent Children]: (a) must have been insured under this Policy on the date the [Employee] [Member] died; and (b) must continue to meet all other requirements for eligibility. Coverage continued under this provision will terminate on the earlier of: the end of {the 12<sup>th</sup> month}; and the date the Spouse [or any Dependent Child] ceases to meet all other requirements for eligibility.

#### **[Continuation for {Layoff, Leave of Absence or Family Medical Leave}**

Insurance for [an Employee] [a Member] [and covered Dependent Children] may be continued until the earliest of the following dates if: (a) [an Employee] [a Member] is on a temporary {layoff, an approved leave of absence or an approved family medical leave}; and (b) required premium contributions are paid when due.

1. [for a layoff, [{six months} after] the end of the month in which the layoff begins;]
2. [for an approved leave of absence: [{six months after] the end of the month in which the leave begins;]
3. [for an approved family medical leave {12 weeks in a consecutive 12-month period.}]

[Such continuation will {run concurrently with, precede} a continuation during any other leave.]]

#### **[Continuation for Military Service**

If [an Employee] [a Member] begins a leave of absence to serve in the armed forces, insurance for the [Employee] [Member] {and his Covered Dependent Children} will continue until the earliest of the following dates, if the required premium is paid:

1. 18 months;
2. the day the [Employee] [Member] fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when coverage is continued under this provision:

1. [any change in benefits that occurs during the period of continuation will apply on the effective date of the change;]
2. [any Active Service requirement will be waived; ]
3. The [Employee] [Member] will be given credit for the time he was covered under this Policy prior to the leave.

If [an Employee] [a Member] does not continue coverage for himself [and his Dependent Children] during such leave and returns to [work] [membership]:

1. the [Employee] [Member] [and his Dependent Children] will be covered on the date the [Employee] [Member] returns to [work] [membership] from the leave. The [Employee] [Member] must return to [work] [membership] as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;

2. any portion of an eligibility waiting period that has not been completed will not be credited during the [Employee's] [Member's] leave.]]

## COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

- [1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane];
- [2. commission or attempt to commit a felony or an assault];
- [3. commission of or active participation in: a riot; or insurrection];
- [4. {bungee jumping;}{ parachuting;}{ skydiving;}{ parasailing;}{ hang-gliding}}];
- [5. declared or undeclared war or act of war];
- [6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as:
  - a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
  - c. a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent;] or
- [7. flight in; boarding; or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
  - [a. except as a fare-paying passenger on a regularly scheduled commercial airline];
  - [b. being flown by the Covered Person or in which the Covered Person is a member of the crew];
  - [c. being used for:
    - [i. crop dusting; spraying or seeding; giving and receiving flying instruction; fire fighting; sky writing; sky diving or hang-gliding; pipeline or power line inspection; aerial photography or exploration; racing; endurance tests; stunt or acrobatic flying]; or
    - [ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);]
  - [d. designed for flight above or beyond the earth's atmosphere];
  - [e. an ultra-light or glider];
  - [f. being used for the purpose of parachuting or skydiving];
  - [g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;]
- [8. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle];
- [9. participation in any motorized race or contest of speed];
- [10. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program];
- [11. Sickness; disease; bodily or mental infirmity; bacterial or viral infection; or medical or surgical treatment thereof; except for any bacterial infection resulting from: an accidental external cut or wound; or accidental ingestion of contaminated food];
- [12. medical or surgical treatment; diagnostic procedure; administration of anesthesia; or medical mishap or negligence; including malpractice];
- [13. travel or activity outside the United States or Canada];
- [14. travel in any Aircraft: owned; leased; or controlled by the Policyholder; or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year];
- [15. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred];
- [16. voluntary ingestion of: any narcotic; drug; poison; gas or fumes; unless: prescribed or taken under the direction of a Physician; and taken in accordance with the prescribed dosage];
- [17. injuries compensable under: Workers' Compensation law; or any similar law];
- [18. occupational injuries for which benefits are not paid under: the Workers' Compensation Law; or any similar law];
- [19. injuries that result from a non-occupational accident];
- [20. a Covered Accident that occurs while on active duty service in: the military; naval; or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days];

In addition, benefits will not be paid for:

- [21. services or treatment rendered by: a Physician; Nurse; or any other person who is:

- a. employed or retained by the Policyholder;
  - b. providing: homeopathic; aroma-therapeutic; or herbal therapeutic services;
  - c. living in the Covered Person's household;
  - d. who is: a parent; sibling; spouse; or child of the Covered Person];
- [22. any Hospital Stay or days of a Hospital Stay that are not appropriate for the condition and locality.]

## [CONVERSION PRIVILEGE]

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- [1. If the Covered Person's insurance or any portion of it ends for a reason other than: non-payment of premium; the Covered Person's Age; or those reasons described in Paragraph 2 below; the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated policy. The Covered Person may not apply for an amount greater than his coverage under this Policy [less the amount of any other group accident insurance for which he becomes eligible within 31 days after the date coverage under this Policy terminated.] The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

The Covered Person must apply for the individual policy within 31 days after his coverage under this Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk.

The individual policy or certificate will take effect on the day following the date coverage under the Policy ended. If the Covered Person dies during this 31-day period as the result of an accident that would have been covered under this Policy, We will pay as a claim under this Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Policy.

2. If the Covered Person's insurance ends because this Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Policy for at least five year's the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
  - a. coverage under this Policy less any amount of group accident insurance: for which he is eligible on the date this Policy is terminated; or for which he became eligible within 31 days of such termination; or
  - b. {\$10,000}

## CLAIM PROVISIONS

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### **Notice of Claim**

Written {or authorized electronic/telephonic} notice of claim must be given to Us: within {31 days} after a Covered Loss occurs or begins; or as soon as reasonably possible. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given to Us: at Our Home Office in Houston, Texas; or such other place as We may designate for the purpose; or to Our authorized agent. Notice should include: the Policyholder's name and policy number; and the Covered Person's name; address; policy; and certificate number.

### **Claim Forms**

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written {or authorized electronic} proof of the nature and extent of the loss for which the claim is made.

### **[Claimant Cooperation Provision**

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

### **Proof of Loss**

Written {or authorized electronic} proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss; then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written {or authorized electronic} notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written {or authorized electronic} proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

[The Plan Administrator of the Policyholder's employee welfare benefit plan (the Plan) has selected the Insurance Company as the Plan fiduciary under federal law for the review of claims for benefits provided by this Policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion: to interpret the terms of the Plan documents; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by the Insurance Company in this capacity shall be final and binding on Participants and Beneficiaries of The Plan to the full extent permitted by law.

The Insurance Company has no fiduciary responsibility with respect to the administration of The Plan except as described above. It is understood that the Insurance Company's sole liability to the Plan and to Participants and Beneficiaries under The Plan shall be for the payment of benefits provided under this Policy.]

### **Time of Payment of Claims**

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written {or authorized electronic} proof of such loss. Subject to due written {or authorized electronic} proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid no later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

### **Payment of Claims**

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered [Employee] [Member], his estate, or the hospital or person rendering services upon request by the group Policyholder.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay { \$1,000 - \$5,000} to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability, unless, before payment is made, We have received at Our home office written notice by or on behalf of another person that the other person claims to be entitled to the payment or some interest in the Policy.

#### **[Payment of Claims to Foreign [Employees] [Members]**

The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered [Employees] [Members] whose place of [employment] [membership] is other than:

- {1. the United States of America;}
- {2. Puerto Rico; or}
- {3. the Dominion of Canada}.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under this Policy.]

#### **Physical Examination [and Autopsy]**

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

#### **Legal Actions**

No action at law or in equity may be brought to recover under this Policy less than 60 days after written {or authorized electronic} proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

#### **Beneficiary**

The beneficiary is the person or persons the [Employee] [Member] names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary [, or to make any assignment of rights or benefits permitted by this Policy.] [A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child.] [Any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child will be paid to the [Employee's] [Member's] estate.]

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the [Employee] [Member] has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the [Employee] [Member] dies while benefits are payable to him, We may make direct payment to [the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of the [Employee] [Member].]

Or

[the estate of the [Employee] [Member].]

#### **Recovery of Overpayment**

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount;
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

## **ADMINISTRATIVE PROVISIONS**

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### **Premiums**

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. [If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day before the reduction took place.]

### **Changes in Premium Rates**

We may change the premium rates from time to time with at least {31 days} advance written notice to the Policyholder. No change in rates will be made until {12 months} after the Policy Effective Date. An increase in rates will not be made more often than once in {a 12-month period}. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
- [2. the terms of the Policyholder's participation change;]
- [3.] a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
- [4.] there is a change in the factors bearing on the risk assumed;
- [5.] any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

### **Payment of Premium**

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder.

If any premium is not paid on the Premium Due Date when due, this Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period section.

### **Grace Period**

- [1. {Policy}]

A Policy Grace Period of {31 days} will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force.]

- [2. Covered Person]

A Grace Period of {31 days} will be granted for payment of required premiums under this Policy. A Covered Person's insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If: no such claims are incurred; and premium is not paid during the grace period; insurance will end on the last day of the period for which premiums were paid.]

## **GENERAL PROVISIONS**

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### **Entire Contract; Changes**

This Policy, including: the endorsements; amendments; and any attached papers; constitutes the entire contract of insurance. No change in this Policy will be valid until: approved by one of Our executive officers; and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

### **Misstatement of Fact**

If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

### **Certificates**

Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list: the benefits; conditions; and limits of this Policy. It will state to whom benefits will be paid.

### **Multiple Certificates**

The Covered Person may have in force only one certificate at a time under this Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.]

[A Covered Person is not eligible for insurance under more than {one certificate providing benefits for accident insurance under group policies issued by Us}. If premium is being paid for more than one such certificate, insurance will be in effect under the certificate with the earliest effective date and premiums paid for certificates which are not in effect will be refunded.]]

### **Assignment**

*Option 1: Include if no rights and benefits are assignable:*

[The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.]

*Option 2: Include when no assignment other than benefits that have become payable is permitted:*

[The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.]

*Option 3: Include if assignment is permissible:*

[We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while: the assignment remains in effect; and insurance under this Policy and the Covered Person's certificate remains in force. We will deal with the assignee as the owner or pledge of the Policy in accordance with the terms of the assignment until We have received at Our home office written notice of termination of the assignment or written notice by or on behalf of some other person claiming some interest in the Policy in conflict with the assignment.]

## **Incontestability**

### **1. Of This Policy or Participation Under This Policy**

All statements made by the Policyholder to obtain this Policy are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; or to deny the validity of this Policy or of participation under this Policy; unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

### **2. Of a Covered Person's Insurance**

All statements made by a Covered Person are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from: the Covered Person's effective date of insurance; or from the effective date of increased benefits; no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

## **[Reporting Requirements**

The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. additional information required by Us.]

## **Policy Termination**

We may terminate coverage on or after [the first anniversary of the policy effective date]. The Policyholder may terminate coverage on any premium due date. Written {or authorized electronic} notice must be given at least {31 days} prior to such premium due date. [Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

## **[Reinstatement**

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are: written application of the Policyholder satisfactory to Us; and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid [, but not to any period more than {60 days} prior to the date of reinstatement.]]

## **Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

## **Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

## **Policy Changes**

We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

**Workers' Compensation Insurance**

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

**Examination of the Policy**

This Policy will be available for inspection at the Policyholder's office during regular business hours.

**Examination of Records**

We will be permitted to examine all of the Policyholder's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

## DESCRIPTION OF [COVERAGES] AND BENEFITS

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This Description of [Coverages and] Benefits Section describes the Accident [Coverages and] Benefits provided by this Policy. Benefit amounts; benefit periods; and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand: all of the terms; conditions; and limitations applicable to these [coverages and] benefits.

### [ACCIDENTAL DEATH BENEFIT

- Covered Loss** We will pay the benefit shown in the *Schedule of Benefits* if a Covered Person dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].
- Exclusions** Exclusions that apply to this Benefit are specified in *Common Exclusions* Section.]

### [ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

- Covered Loss** We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable.] If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

### Definitions

**[Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.]

**[Loss of Sight** means the total, permanent loss of all vision in one eye which is irrecoverable by: natural; surgical; or artificial means.]

**[Loss of Speech** means total and permanent loss of audible communication which is irrecoverable by: natural; surgical; or artificial means.]

**[Loss of Hearing** means total and permanent loss of ability to hear any sound {in both ears} which is irrecoverable by: natural; surgical; or artificial means.]

**[Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand** means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).]

**[Loss of Toes** means complete Severance through the

metatarsalphalangeal joint.]

**[Paralysis or Paralyzed** means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.]

**[Quadriplegia** means total Paralysis of both upper and both lower limbs.]

**[Hemiplegia** means total Paralysis of the upper and lower limbs on one side of the body.]

**[Paraplegia** means total Paralysis of both lower limbs or both upper limbs.]

**[Uniplegia** means total Paralysis of one upper or one lower limb.]

**[Coma** means a profound state of unconsciousness: which resulted directly and independently from all other causes from a Covered Accident; and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.]

**[Severance** means the complete and permanent separation and dismemberment of the part from the body.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[ADDITIONAL [ACCIDENTAL DEATH AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other {Accidental Death and Dismemberment} benefits payable.]

#### **[ARMED FORCES COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while he is on active duty in any Armed Forces.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

#### **[EXPOSURE AND DISAPPEARANCE COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within {1 – 7 years} from the date of: the wrecking; sinking; or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable subject to the following conditions if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while the Covered Person is a member of the U.S. Military Reserve or National Guard.

While the Covered Person is a member of the U.S. Military Reserve or National Guard, coverage under this Policy will remain in force beyond the 31-day active duty training period and continue:

1. during the Covered Person's initial training period;
2. if the Covered Person is called to active duty [for a domestic emergency].

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[OWNED AIRCRAFT COVERAGE**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs: during travel or flight in; including getting in or out of; any Aircraft that is: owned; leased; operated; or controlled by the Policyholder (or any of its subsidiaries or affiliates). A record of eligible Aircraft will be maintained by the Policyholder and available for review by Us at any time during normal business hours. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to: breakdown; repair; servicing; loss; or destruction.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[PILOT COVERAGE**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while: the Covered Person is flying as a licensed pilot [or member of the crew] of an Aircraft; and meets all of the following requirements:

- [1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by Us;]
- [2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by Us;]
- [3. completes and maintains a combined minimum of {200 hours} of military, private or professional logged flight hours;]
- [4. is flying as a pilot [or member of the crew] of an Aircraft traveling on or transacting business for the Policyholder. All trips must have been authorized in advance by the Policyholder;]
- [5. is flying as a pilot [or member of the crew] of an Aircraft [described below] or [on a list of eligible Aircraft maintained by the Policyholder, including a substitute Aircraft with no greater seating capacity while a [specified] or [listed] Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction;]
- [6. is flying as a pilot [or member of the crew] of an Aircraft that is [not] owned, leased, operated or controlled by the Policyholder;]
- [7. is not giving or receiving flight instruction.]

**[Description of Aircraft Covered** {XXXXXXXXX will list: type of Aircraft; license number; and passenger seating capacity: Boeing 727; License # PA12345; passenger seating capacity: 45}]

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[WAR RISK COVERAGE**

Benefits for {Accidental Death and Dismemberment} as shown in the *Schedule of Covered Losses*, will be payable, subject to the following conditions and exclusions, if a Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during war or acts of war that occur in:

- {1. any specifically described geographic area such as Saudi Arabia, Iran, Serbia}; or
- {2. a generally described geographic area such as worldwide, excluding the United States and its territories and possessions.}

The Policyholder may cancel this war risk coverage at any time by sending written notice to Us at Our home office address. Coverage will be canceled upon receipt of notice or a date specified by the Policyholder.

We may cancel this coverage at any time by providing written notice to the Policyholder at least {10 days} prior to termination of this coverage. Any unearned premium will be promptly returned to the Policyholder.

**Exclusions** This benefit does not provide coverage when a Covered Loss occurs:  
[1. in the United States and its territories and possessions; or]  
[2. in any nation of which the Covered Person is a citizen.]

{[Other} exclusions that apply to this coverage are in the *Common Exclusions* Section.]}

#### **[ADDITIONAL ACCIDENT BENEFITS]**

{[Accidental Death and Dismemberment benefits} are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other {Accidental Death and Dismemberment benefit} payable.]

#### **[ADDITIONAL OCCUPATIONAL BENEFIT]**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss which results directly and independently of all other causes from a Covered Accident that occurs while the covered [Employee] [Member] is on the Policyholder's premises and engaged in the course of his [job] [membership] [or on business travel pre-authorized by the Policyholder].

[Business travel begins at the actual start of a business trip that has been pre-authorized by the Policyholder, whether the trip starts at the covered [Employee's] [Member's]: home; place of work; or another place. Business travel coverage:

1. ends when the covered [Employee] [Member] arrives at his: home; or place of work; whichever happens first; and
2. is not in effect during the covered [Employee's] [Member's] Personal Deviation.]

[Business travel includes: riding in; or getting on or off of; an Aircraft, but only if:

1. the covered [Employee] [Member] is riding as a passenger only, and not as a pilot or member of the crew; and
2. the Aircraft is not being used for any of the following:
  - a. crop dusting, spraying or seeding;
  - b. fire fighting;
  - c. sky writing;
  - d. sky diving or hang gliding;
  - e. pipeline or power line inspection;
  - f. aerial photography or exploration;
  - g. racing;
  - h. endurance tests, stunt or acrobatic flying;
  - i. any operation which requires a special permit from the FAA, even if it is granted unless the permit is required only because of the territory flown over or landed on;
  - j. giving or receiving flying instruction.]

**Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs: prior to the end of the trip; [or within {one hour } before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]

**Exclusions** [Business travel coverage is not provided during:

1. normal commuting between the covered [Employee's] [Member's] home and place of work; or
2. the covered [Employee's] [Member's] Personal Deviation {in excess of 30 days}.]

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT**

We will pay counseling sessions, up to the Maximum Benefit Amount shown in the *Schedule of Benefits* and subject to the following conditions and exclusions, when the Covered Person {and/or Immediate Family Member} requires bereavement and trauma counseling because the Covered Person suffered a Covered Loss that resulted directly and independently of all other causes from a Covered Accident. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within {one year} from [the date of the Covered Accident causing the Covered Loss];
2. the expense is charged for a bereavement or trauma counseling session for the Covered Person {and/or one or more of his Immediate Family Members};
3. counseling is provided under the care, supervision or order of a Physician;
4. a charge would have been made if no insurance existed.

**Definitions** For purposes of this benefit:

**Immediate Family Member** means a person who is related to the Covered Person in any of the following ways: Spouse; brother-in-law; sister-in-law; son-in-law; daughter-in-law; mother-in-law; father-in-law; parent (includes stepparent); brother or sister (includes stepbrother or stepsister); or child (includes legally adopted child or stepchild).

**Exclusions** Covered bereavement and trauma counseling benefits do not include any expense for which the Covered Person is entitled to benefits under any Workers' Compensation Act or similar law.

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BOMB SCARE, BOMB SEARCH OR BOMB EXPLOSION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. the covered [Employee] [Member] is on the Policyholder's premises when the Covered Accident occurs;
2. the Covered Accident is caused by or results from a Bomb Scare, Search or Explosion, as defined below;
3. the covered [Employee] [Member] is an authorized participant of a team or squad engaged in a Bomb Search or related activity;
4. the Policyholder authorizes the covered [Employee's] [Member's] participation and sanctions the search.

**Definitions** For purposes of this benefit:

**Bomb** means any real or dummy explosive device placed with intent to: damage; scare; or cause injury.

**Scare** means any real or false report of a Bomb on the premises of the Policyholder .

**Search** means any organized search for a reported Bomb.

**Explosion** means any detonation of a Bomb on the Policyholder's premises which appears to have been intended to cause injury or unlawful property damage, whether or not the presence of the Bomb was reported before detonation. [It does not include: any act of declared or undeclared war in the United States of America or Canada; or acceptance of known explosives as cargo.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section. ]

**[BULLETPROOF VEST BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] {who is Age 18 or older} is on official duty for the Policyholder and is shot during a Covered Accident while wearing a Bulletproof Vest and:

1. the Bulletproof Vest fails to prevent the bullet's penetration through the vest; and
2. such penetration results, directly and independently of all other causes, in {a Covered Loss, Covered Injury}.

**Definition** For purposes of this benefit:

**Bulletproof Vest** means a protective vest designated as {Threat Level II-A; Threat Level II; or Threat Level III-A} [manufactured by a vendor designated by the Policyholder] and [purchased not more than {five years} before the Covered Accident.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[BURIAL AND CREMATION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, for burial or cremation of the covered [Employee] [Member] who dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[BUSINESS TRAVEL BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a business trip authorized in advance by the Policyholder. The Covered Loss must be sustained:

1. in the course of the covered [Employee's] [Member's] [job] [membership];
2. away from the premises of the Policyholder in the covered [Employee's] [Member's] city of permanent assignment].

Coverage will begin at the actual start of a business trip authorized by the Policyholder. It does not matter if the trip starts at the covered [Employee's] [Member's]: home; place of work; or any other place. Coverage will end when the covered [Employee] [Member] arrives at his: home; or place of work; whichever happens first.

**[Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs prior to the end of the trip [or within {one hour} before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]]

- Exclusions** Coverage for business travel is not provided during [any of the following]:
1. normal commuting between the covered [Employee's] [Member's] home and place of work;
  - [2. travel in an Aircraft: owned; leased; operated; or controlled by the Policyholder;]
  3. travel to another location where the [Employee] [Member] is expected to be assigned for more than {60 days} by the Policyholder;
  4. a covered [Employee's] [Member's] Personal Deviation [in excess of {31 days}].

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[CHILD CARE CENTER BENEFIT**

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered [Employee] [Member][Spouse] results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. coverage for his Dependent Children was in force on the date of the Covered Accident causing his death: and
2. one or more surviving Dependent Children is under Age {13}; and
  - [a. was enrolled in a Child Care Center on the date of the Covered Accident; or]
  - [b. enrolls in a Child Care Center within { 90 - 365 days} from the date of the Covered Accident].

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each {12 month} period that begins after the date of the covered [Employee's] [Member's][Spouse's] death. A claim must be submitted to Us at the end of each {12 month} period [with proof of enrollment and attendance]. A {12 month} period begins:

- [1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered [Employee's] [Member's][Spouse's] death; or]
2. on the first of the month following the covered [Employee's] [Member's][Spouse's] death, if the Dependent Child was enrolled in a Child Care Center before the covered [Employee's] [Member's][Spouse's] death.

Each succeeding {12 month} period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

**Definitions** For purposes of this benefit:

**Child Care Center** is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

**[Surviving Spouse** will include the covered [Employee] [Member] and covered Spouse.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[COMMON CARRIER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Common Carrier** means:

1. a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or a similar air transport service of another country.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[EMERGENCY ROOM BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Emergency Room Treatment due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Definition** For purposes of this benefit:

**Emergency Room** means a trauma center or a special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[ESCALATOR BENEFIT**

We will increase the Covered Person's Principal Sum by {the dollar amount or the percentage of Principal Sum} shown on the *Schedule of Benefits*, subject to the following conditions and exclusions. [The Covered Person must be under Age {55; 60} to be eligible for this benefit.] [Benefit amounts for {a covered Spouse, Dependent Child} will not be increased.]

[The Principal Sum used to calculate this benefit:

1. will be the amount in force when the Covered Person first becomes insured for this benefit;
2. will not compound previous Escalator benefit amounts.]

Increases will become effective on each {Policy or certificate anniversary} after the Covered Person has been insured for {12 consecutive months}. Benefit increases will occur automatically at the end of each {12 month} period, for a maximum of {five years}.

[Increases provided by this benefit will be calculated separately for each additional Principal Sum the Covered Person elects. The total amount of all increases will not exceed the highest amount shown in the *Schedule of Benefits*.

[If the Covered Person's Principal Sum is reduced, any increases provided under this benefit will be reduced in the same proportion.]

**Exclusions** [This benefit will not apply to any *Bonus Benefit*.]

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT**

We will pay the amount shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and

independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault as described below. [A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid.] [The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder. ]

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

[We will pay a Hospital Stay Benefit, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

1. the Covered Person is covered for Hospital Stay benefits under this Policy;]
2. the Hospital Stay begins within {30 days} of the violent crime/felonious assault;
3. the Hospital Stay is at the direction and under the care of a Physician;]
4. the Covered Person provides proof satisfactory to Us that his Hospital Stay was necessitated to treat Covered Injuries sustained in a Covered Accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Definitions** For purposes of this benefit:

**Family Member** means the Covered Person's: parent; step-parent; Spouse or former Spouse; son; daughter; brother; sister; mother-in-law; father-in-law; son-in-law; daughter-in-law; brother-in-law; sister-in-law; aunt; uncle; cousins; grandparent; grandchild; and stepchild.

**Fellow [Employee] [Member]** means [a person employed by] [a member of] the same Entity as the Covered Person or by an Entity that is an affiliated or subsidiary entity. It shall also include any person who was so [employed] [qualified as a member], but whose [employment] [membership] was terminated not more than {45 days} prior to the date on which the defined violent crime/felonious assault was committed.

**Member of the Same Household** means a person who maintains residence at the same address as the Covered Person.

**Exclusions** Benefits will not be paid for treatment of any Covered Injury sustained or Covered Loss incurred during any:

1. violent crime or felonious assault committed by the Covered Person; or
2. felonious assault or violent crime committed upon the Covered Person by: a Fellow [Employee] [Member]; Family Member; or Member of the Same Household.

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[HIV OCCUPATIONAL ACCIDENT BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the covered [Employee] [Member] suffers a Covered Injury resulting, directly and independently of all other causes, from a Covered Accident. Such Covered Accident must: occur during the performance of Occupational Duties; and result in the covered [Employee]

[Member] acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within {one year} of the Covered Injury.

In order to receive this benefit, the covered [Employee] [Member] must satisfy all of the following:

1. submit a Workers' Compensation Injury report to the Policyholder within {48 hours} of the Covered Accident that occurs during the performance of Occupational Duties;
2. test negative for Human Immunodeficiency Virus (HIV) antibodies within {48 hours} of such Covered Accident;
3. test positive for Human Immunodeficiency Virus (HIV) antibodies in a subsequent Blood Test within {one year} of the date of the Covered Accident.

**Definitions** For purposes of this benefit:

**Occupational Duties** means the performance of normal work duties on behalf of the Policyholder.

**HIV** means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

**Blood Test** means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by Us.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay the Covered Home Alteration and Vehicle Modification Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss, other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. the Covered Person requires home alteration or vehicle modification within {one year} of the date of the Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOSPITAL STAY BENEFIT**

We will pay the {daily, monthly} benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires a Hospital Stay due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Hospital Stay must meet all of the following:

1. be at the direction and under the care of a Physician;
2. begin within {30 days} of the Covered Accident;
- [3. begin while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay that continues after the end of the Benefit Waiting Period as shown in the *Schedule of Benefits*. Benefits will be paid retroactively to the first day of the Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

### **[PRIVATE PASSENGER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident while: driving; riding as a passenger in; or getting in or out of; a Private Passenger Automobile.

*Include if Accidental Death and Dismemberment Benefits are not included in the issued policy.*

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Private Passenger Automobile** means a validly registered: four wheel private passenger car (including Policyholder-owned cars); campers; motorized golf carts; motor homes; non-motorized bicycles; non-motorized adult tricycles; station wagons; sport utility vehicles; pick-up trucks; and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as: a taxicab; bus; or other public conveyance will not be considered a Private Passenger Automobile.

Any vehicle not defined above will not be considered a Private Passenger Automobile.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

### **[REHABILITATION BENEFIT**

We will pay the Rehabilitation Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person requires rehabilitation after sustaining a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Covered Person must require Rehabilitation within {two years} after the date of {the Covered Accident, Covered Loss}.

**Definition** For purposes of this benefit:

**Rehabilitation** means: {medical services; supplies; or treatment; or Hospital confinement (or part of a Hospital confinement)} that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the Covered Person's Covered Loss;
2. meet generally accepted standards of medical practice;
3. are performed under: the care; supervision; or order of a Physician;
4. prepare the Covered Person to return to his or any other occupation.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

### **[SEATBELT [AND AIRBAG] BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. [if airbag benefit is included: An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).]

Verification of proper use of the seatbelt at the time of the Covered Accident [and that the Supplemental Restraint System properly inflated upon impact] must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

[If: such certification or police report is not available; or it is unclear whether the Covered Person was wearing a seatbelt [or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System]; We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.]

[In the case of a child, seatbelt means: a child restraint; as required by state law and approved by the National Highway Traffic Safety Administration; properly secured; and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.]

**Definitions** For purposes of this benefit:  
[if airbag benefit is included: **Supplemental Restraint System** means an airbag that inflates upon impact for added protection to the head and chest areas.]

**Automobile** means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to: a sedan; station wagon; sport utility vehicle; or a motor vehicle of the pickup; van; camper; or motor-home type. Automobile does not include: a mobile home; or any motor vehicle which is used in mass or public transit.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[SPECIAL EDUCATION BENEFIT**

We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for each qualifying Dependent Child [and][a surviving covered Spouse] who {is/are} insured under the covered [Employee's] [Member's] certificate on the date he dies [or has been Totally Disabled during the Benefit Waiting Period for Permanent Total Disability benefits.] The Covered Person's death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit [or Permanent Total Disability Benefits] {is, are} payable under this Policy. This benefit is subject to the conditions and exclusions described below.

[A qualifying Dependent Child must:

1. a. [be enrolled as a full-time student in an accredited school of higher learning beyond the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident]; or  
b. [be at the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident and then enroll as a full-time student at an accredited school of higher learning within {365 days} from the date of the Covered Accident and continue his education as a full-time student.]
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in this Policy;
2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying surviving Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in this Policy;
2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.

A qualifying surviving Spouse must:

1. enroll in any accredited school for the purpose of retraining or refreshing skills needed for employment within {one year} of the date of the covered [Employee's] [Member's] Covered Accident;
2. remain enrolled in such accredited school; and
3. incur expenses: payable directly to; or approved by; such school.]

*Always include this language:*

Payments will be made to each qualifying Dependent Child [or to the child's legal guardian, if the child is a minor] at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits], if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

[If no Dependent Child qualifies for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

[Payments will be made to the surviving Spouse at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Spouse's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the date the surviving Spouse enrolls in an accredited school for the first time following the date the [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits]. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.]

[If a surviving Spouse does not qualify for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[TOTAL DISABILITY WEEKLY INCOME BENEFIT**

We will pay weekly benefits shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, to the Covered Person whose Total Disability results: directly and independently of all other causes from; and within {31 days} of; a Covered Accident. Weekly disability benefits will begin when the Totally Disabled Covered Person satisfies the Benefit Waiting Period shown in the *Schedule of Benefits* and will end on the earliest of the date he:

1. dies;
2. is no longer Totally Disabled;
3. fails to provide certification by a Physician that he remains Totally Disabled;
4. is eligible to receive [Accidental Death and Dismemberment benefits] [Permanent Total Disability benefits] for the same Covered Accident];
5. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits*.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[WAIVER OF PREMIUM BENEFIT**

We will waive premiums, beginning with those due on and after the end of the Benefit Waiting Period, for a covered [Employee] [Member] [ Spouse] who:

- a. becomes Totally Disabled [within {30 days} of] [after suffering] a Covered Loss that results directly and independently of all other causes from a Covered Accident; and

- b. satisfies all of the following conditions:
1. Total Disability must begin before the covered [Employee's] [Member's] [Spouse's] {60th} birthday;
  2. We must receive proof satisfactory to Us that Total Disability was continuous during the Benefit Waiting Period;
  3. insurance under this Policy remains in force during the Benefit Waiting Period.

The covered [Employee] [Member] must submit satisfactory proof of continuous Total Disability to Us no more than {three to 12 months} after the date he [became Totally Disabled] [satisfies the Benefit Waiting Period]. Proof of continuing Total Disability must be submitted to Us during the last {three months} of each year. We may have the covered [Employee] [Member] [Spouse] examined as often as reasonably necessary while Totally Disabled, but not more than once a year after two years.

The amount of insurance for which premiums will be waived is the amount in force on the date the covered [Employee] [Member] [Spouse] became Totally Disabled. This amount will be subject to any age reductions applicable during the Benefit Period. Any increases in coverage that would have occurred if the covered [Employee] [Member] [Spouse] were not Totally Disabled will be deferred, as described in the *Deferred Effective Dates* provision of the *Eligibility and Effective Date* section of this Policy.

Premiums will cease to be waived on the earliest of the following dates:

1. the premium due date following the date the covered [Employee] [Member] [ Spouse] ceases to be Totally Disabled;
2. the date the covered [Employee] [Member] [Spouse] refuses to be examined or fails to provide required proof of continuing Total Disability;
3. the premium due date following the end of the Benefit Period shown in the *Schedule of Benefits*.

When premiums cease to be waived as described above, insurance provided under this Policy will continue as long as premiums are paid when due.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**Catlin Insurance Company, Inc.**  
**Statutory Home Office: 1130 Post Oak Boulevard, Suite**  
**2325, Houston, TX 77056**  
**Administrative Office: 3340 Peachtree Road N.E., Suite**  
**2950, Atlanta, GA 30326**  
**A Stock Insurance Company**

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**ARKANSAS GROUP ACCIDENT CERTIFICATE**

THIS CERTIFICATE IS A QUALIFIED GROUP ACCIDENT INSURANCE CONTRACT

Certifies that the Insured is covered under the Policy issued to the Policyholder.

"We", "Our" and "Us" are used to refer to the Catlin Insurance Company, Inc.

This certificate is not the Policy. It is evidence of the [Employee's] [Member's] coverage under the Policy. Coverage is subject to the Policy provisions. The Policy was issued to the Policyholder. The [Employee] [Member] may inspect the Policy at the Policyholder's office during normal business hours.

CAUTION: If the [Employee] [Member] as misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased had such fact been correctly stated.

A copy of the application is attached to this certificate. The best time to clear up any questions is now, before a claim arises. If you have any questions contact Us at this address:

Catlin Insurance Company, Inc.  
{P.O. Box XXXXX}  
{Your city, Your state 0000}

This Certificate describes the terms and conditions of insurance. The laws of the State of Issue govern the Policy.

Signed for Catlin Insurance Company, Inc. at its Home Office, 1330 Post Oak Boulevard, Suite 2325, Houston, Texas 77056.



Secretary

President

Countersigned \_\_\_\_\_

Where Required By Law

### **EFFECTIVE DATE AND TERM**

The Policy starts on the Policy Effective Date. The Covered Person's coverage starts on the Covered Person's Effective Date stated in the Certificate Identification. It stays in-force for the period for which the Covered Person's premium has been paid.

The Covered Person's coverage may be continued in force, as provided in the [Continuation of Insurance];[Continuation for {Layoff; Leave of Absence; Family Medical Leave}];[Continuation for Military Service] clause. If the Policy is not renewed or the Covered Person is no longer eligible for coverage the Covered Person's coverage will cease at the termination date.

## CERTIFICATE IDENTIFICATION

POLICYHOLDER:	{ABC Company, Inc.}
POLICY NUMBER:	{Specimen}
POLICY EFFECTIVE DATE:	{January 1, 2008}
POLICY ANNIVERSARY DATE:	{January 1}
STATE OF ISSUE:	{Any State}
CERTIFICATE NUMBER:	{00000000000}
{COVERED PERSON}:	{John Doe}
{COVERED PERSON'S} DATE OF BIRTH:	{January 1, 2009}
{COVERED PERSON'S} ADDRESS:	{1000 Main Street {Your Town}, {Texas} {10000}
{COVERED PERSON'S} ORIGINAL EFFECTIVE DATE:	
{COVERED PERSON'S} CURRENT COVERAGE EFFECTIVE DATE:	

**(PLEASE NOTE THAT THIS SCHEDULE PAGE REPLACES ANY SCHEDULE PAGE PREVIOUSLY ISSUED TO YOU)**

## SCHEDULE OF BENEFITS

### [Covered Classes

Class 1	All full-time Employees of the Policyholder working at least [20-40] hours per week.
Class 2	All part-time Employees working at least [0-40] hours per week.]
Class 3	All active Members of the Policyholder.
Class 4	All Spouses and Dependent Children of Class 1, 2, or 3. ]

### [Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the [Employee] [Member] must be in a Covered Class to be eligible for coverage. [It will be extended by the number of days the [Employee] [Member] is absent from scheduled work.]

For [Employees] [Members] added [{31 days} or more] before the Policy Effective Date:	{No Waiting Period}
For [Employees] [Members] added [less than {31 days} before, or] after the Policy Effective Date:	{One month}{30 days}{31 days}]

### [Time Period for Loss

[Any Covered Loss must occur within:	{90 - 365 days} of the Covered Accident]]
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**This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in the Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Covered Person's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.**

### [ACCIDENTAL DEATH BENEFIT

[[Employee] [Member] Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}}
[Spouse Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}}
[Dependent Child(ren) Principal Sum:	{\$0 - \$1,000,000}}

### [Age Reductions

A Covered Person's Principal Sum will be reduced by the percentage shown below:

Age	Percentage of Benefit Amount
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member]]]]

**[Aggregate Limit of Liability]**

Each Covered {Aircraft} Accident	{\$0 - \$5,000,000 for all Covered Persons}
Applies to:	{Accidental Death and Dismemberment Benefits or Accidental Death Benefits or all coverage and benefits provided by the Policy}

If this aggregate amount does not allow all Covered Persons to be paid the amounts the specified benefits otherwise provide, the amount paid for each Covered Person is the proportion each Loss bears to the Aggregate Limit of Liability. [Covered Aircraft Accident means a Covered Accident involving a scheduled or chartered flight in an Aircraft.]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS]**

[[Employee] [Member] Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}
[Spouse Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}
[Dependent Child(ren) Principal Sum:	{\$0 - \$1,000,000}

**SCHEDULE OF COVERED LOSSES**

<b>Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{100% of the Principal Sum}}
[Loss of Two or More Hands or Feet	{100% of the Principal Sum}}
[Loss of Sight of Both Eyes	{100% of the Principal Sum}}
[Loss of Speech and Hearing (in both ears)	{100% of the Principal Sum}}
[Loss of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Sight in One Eye	{50% of the Principal Sum}}
[Severance and Reattachment of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Speech	{50% of the Principal Sum}}
[Loss of Hearing (in both ears)	{50% of the Principal Sum}}
[Loss of Thumb and Index Finger of the Same Hand	{25% of the Principal Sum}}
[Loss of all Four Fingers of the Same Hand	{25% of the Principal Sum}}
[Loss of all the Toes of the Same Foot	{20% of the Principal Sum}}

**[Age Reductions]**

A Covered Person's Principal Sum will be reduced by the percentage shown below:

<b>Age</b>	<b>Percentage of Benefit Amount</b>
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member].]

**[ADDITIONAL ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits. ]

<b>[ARMED FORCES COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[EXPOSURE AND DISAPPEARANCE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[OWNED AIRCRAFT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[PILOT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[WAR RISK COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]

**[ADDITIONAL ACCIDENT BENEFITS ]**

[Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other {Accidental Death and Dismemberment benefits} payable.]

<b>[ADDITIONAL OCCUPATIONAL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT</b>	
Benefit Amount	{\$75 per session}
Maximum Number of Sessions	{10 sessions}
Maximum Benefit Per Covered Accident	[\$750]
<b>[BOMB SCARE, BOMB SEARCH, OR BOMB EXPLOSION BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]

<b>[BULLETPROOF VEST BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]	
<b>[BURIAL AND CREMATION BENEFIT</b>	[\$0 - \$5,000}]	
<b>[BUSINESS TRAVEL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]	
<b>[CHILD CARE CENTER BENEFIT</b>		
Benefit Amount	[\$0 - \$3,000 per year}	
Maximum Benefit Period	{to Age {13} for each surviving Dependent Child}]	
<b>[COMMON CARRIER BENEFIT</b>	{50%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i>	
	<b>[Covered Loss</b>	
	<b>Benefit</b>	
	[Loss of Life	[\$10,000}]
	[Loss of Two or More Hands or Feet	[\$10,000}]
	[Quadriplegia	[\$10,000}]
	[Hemiplegia	[\$5,000}]
	[Uniplegia	[\$5,000}]
	[Coma	[\$5,000}]]]
<b>[EMERGENCY ROOM BENEFIT</b>		
Benefit Amount	[\$200}	
Maximum Payable Visits per Calendar Year	{5}	
Maximum Benefit Per Covered Accident	[\$1,000}]	
<b>[ESCALATOR BENEFIT</b>		
Periodic Increase	{10% of the Principal Sum}	
Frequency of Increases	{Annually}	
Maximum Total Increase	{50% of the Principal Sum}]	
<b>[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT</b>		
Accidental Death and Dismemberment Benefit	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i>	
Hospital Stay Benefit	[\$100 per day}	
Maximum Benefit Period	{730 days per Hospital Stay per Covered Accident}]	
<b>[HIV OCCUPATIONAL ACCIDENT BENEFIT</b>	{25%} of the Principal Sum [subject to a maximum of {\$100,000}]]	
<b>[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT</b>		
Benefit	{10% of the Principal Sum subject to a maximum of \$25,000}]	



**[INITIAL PREMIUM RATES**

Premium Rate:	{Premium amounts will vary based on the plan of benefits: \$123.45} per {covered [Employee] [Member], Covered Person, and covered Spouse, per Dependent Child, per month}
Mode of Premium Payment:	{Monthly; Quarterly; Semi-Annually; Annually}
Contributions:	The cost of coverage is paid by the {Policyholder; Policyholder and Covered Person;
Premium Due Dates:	The Policy Effective Date and the first day of each succeeding {interval}[month].

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of the Policy. [Each Covered Person's premiums are based on his plan of benefits and class and may increase on the next premium due date.

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## GENERAL DEFINITIONS

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Please note that certain words used in the Policy have specific meanings. The words defined below and capitalized within the text of the Policy have the meanings set forth below.

<b>[Active Service</b>	<p>[An [Employee] [Member] will be considered in Active Service with the Policyholder on any day that is either of the following:</p> <ol style="list-style-type: none"><li>1. [one of the Policyholder's scheduled work days on which the [Employee] [Member] is performing his regular duties on a full-time basis, either at one of the Policyholder's usual places of business or at some other location to which the Policyholder's business requires the [Employee] [Member] to travel;]</li><li>2. [a scheduled holiday; vacation day; or period of approved paid leave of absence; other than sick leave, only if the [Employee] [Member] was in Active Service on the Preceding scheduled workday;]</li><li>3. [a day on which the Member meets all the conditions of membership of the Policyholder.]]</li></ol> <p>[An eligible Dependent Child or eligible Spouse of the [Employee] [Member] is considered in Active Service if he is none of the following:</p> <ol style="list-style-type: none"><li>1. an Inpatient in a Hospital; or receiving Outpatient care for chemotherapy or radiation therapy;</li><li>2. Confined at home under the care of Physician for Sickness or Injury;</li><li>3. Totally Disabled.]]</li></ol>
<b>[Age</b>	<p>A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under the Policy. {Thereafter, it is his Age attained on: [the last Policy anniversary;] or [his last birthday.]}]</p>
<b>[Aircraft</b>	<p>A vehicle which:</p> <ol style="list-style-type: none"><li>1. has a valid certificate of airworthiness; and</li><li>2. is being flown by a pilot with a valid license to operate the Aircraft.]]</li></ol>
<b>[Certificate</b>	<p>The Certificate is not the Policy and is evidence of the Employee/Member's coverage under the Policy. Coverage is subject to the Policy provisions.]]</p>
<b>Complications of Pregnancy</b>	<p>Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; but does not include: false labor; pre-term or premature labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning Sickness; hyperemesis gravidarum; pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Also included is: a non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.</p>
<b>[Core Plan</b>	<p>The noncontributory plan of benefits provided under the Policy.]]</p>

**Covered Accident**

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under the Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. [occurs while the Covered Person is {any of the following may be included: attending, participating in, or traveling to and from any event sponsored by the Policyholder};
4. is not otherwise excluded under the terms of the Policy.

**[Covered Injury**

Any bodily harm that results directly and independently of all other causes from a Covered Accident.]

**[Covered Loss**

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the Schedule of Covered Losses;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.]

**Covered Person**

An eligible person in a covered class, as shown in the Schedule of Benefits: for whom an enrollment form has been accepted by Us; and required premium has been paid when due; and for whom coverage under the Policy remains in force. [The term Covered Person shall include, where the Policy provides coverage, an eligible Spouse and eligible Dependent Children.]

**[Dependent Child(ren)**

An [Employee's] [Member's] unmarried child who meets the following requirements:

1. A child from live birth to {19} years old;
2. A child who is {19} or more years old but less than {23} years old, enrolled in a school [as a full-time student] and primarily supported by the [Employee] [Member];
3. A child who is {19} or more years old, chiefly dependent on the [Employee] [Member] for support and maintenance and incapable of - sustaining employment by reason of mental retardation or physical disability, who became so incapable prior to his 19<sup>th</sup> birthday. Notice of the child's condition and dependence must be submitted to Us . If the incapacity or dependency is later removed or terminated, the [Employee] [Member] must notify Us of the change.

A child, for purposes of this provision, includes an [Employee's] [Member's]:

1. natural child;
2. child under the charge, care, and control of the [Employee] [Member] whom the [Employee] [Member] has filed a petition to adopt, until the dismissal or denial of the petition for adoption;
3. stepchild [who resides with the [Employee] [Member]];]
4. [child for whom the [Employee] [Member] is legal guardian.]

[If an [Employee] [Member] who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with the [Employee] [Member] for at least [six consecutive months] and intend to reside with the [Employee] [Member] for an indefinite period of time.]]

**[Domestic Partners**

A person of the same or opposite sex who:

1. shares the covered [Employee's] [Member's] permanent residence;
2. has resided with the covered [Employee] [Member] continuously for at least {six months to two years} and is expected to reside with the covered [Employee] [Member] indefinitely;
3. Is financially interdependent with the covered [Employee] [Member] in each of the following ways:
  - a. by holding one or more credit or bank accounts, including a checking account, as joint owners;]
  - b. by owning or leasing their permanent residence as joint tenants;]
  - c. by naming, or being named by, the covered [Employee] [Member] as a beneficiary of life insurance or under a will;]
  - d. by each agreeing in writing to assume financial responsibility for the welfare of the other;]]
4. has signed a Domestic Partner declaration with the covered [Employee] [Member], if the covered [Employee] [Member] resides in a jurisdiction which provides for a Domestic Partner declaration;]
5. has not signed a Domestic Partner declaration with any other person within the last {12- 24 months;]
6. is no less than {any Age from 18 to 23} years not more than { 60 - 70} years of age;
7. is not legally permitted to marry the covered [Employee] [Member];]
8. is not legally married to any other person;
9. is not a blood relative any closer than would prohibit legal marriage.

[In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.]

A covered [Employee] [Member] may insure a Domestic Partner if all of the following conditions are met:

1. the covered [Employee] [Member] has not been married to any person within the past {12 - 24} months;
2. the Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the covered [Employee] [Member];
3. The covered [Employee] [Member] and the Domestic Partner furnish a notarized affidavit/signed statement reflecting these requirements, and an agreement to notify Us if the requirements cease to be met, on a form acceptable to Us.]]

**[Effective Date**

The date on which insurance under the Policy begins as shown in the Schedule of Benefits.]

**[Emergency Room Treatment**

Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in deterioration to the point of placing a Covered Person's life in jeopardy or cause serious impairment to bodily functions.]

**Employee**

For eligibility purposes, an Employee of the Policyholder who is in one of the covered classes. [The term does not include Employees who work less than {20 - 30 hours per week} for the Policyholder.]]

**[Employer**

The Policyholder and any affiliates, subsidiaries or divisions shown in the *Schedule of Covered Affiliates* and which are covered under the Policy on

the date of issue or subsequently agreed to by Us.]

**[He, His, Him**

Refers to any individual, male or female.]

**[Hospital**

An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

[Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.]

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.]]

**[Hospital Stay**

A confinement in a Hospital, ordered by a Physician, over a period of time when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least {90 days - 180 days}.

**[Inpatient**

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.]

**[Insured**

A person: (1) who is a member of an eligible class of person as described in the Schedule of Benefits; (2) for whom premium has been paid; and (3) while covered under this Policy.]

**[Member**

For eligibility purposes, a Member is any one of the following:

- [1. an Employee of the Policyholder, [not including a temporary or seasonal Employee];]
- [2. an Employee of a Member in good standing of a Policyholder [, not including a temporary or seasonal employee];]
- [3. a person who meets all of the conditions of membership of a Policyholder];

[and who is [Optional, a United States citizen or has a permanent alien registration card and who is] in one of the Covered Classes.]]

<b>[Nurse</b>	A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not: <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household; or</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>
<b>[Outpatient</b>	A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.]
<b>[Permanent Total Disability</b>	An [Employee] [Member] [Spouse] who is Totally Disabled and is expected to remain Totally Disabled, as certified by a Physician, for the rest of his life.
<b>[Physical Therapist</b>	Any practitioner of physical therapy who is duly licensed in the state where he is practicing and who is practicing within the scope and limitations of that license.]
<b>[Physician</b>	A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household;</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>
<b>[Policy</b>	A legal contract between the Policyholder and the Company which describes the terms and conditions of insurance subject to its provisions, limitations and exclusions.]
<b>Policyholder</b>	The entity to which the Policy is issued and will include any affiliate or subsidiaries or divisions shown in the "Eligibility for Insurance" section.
<b>[Rehabilitation Facility</b>	A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which: <ol style="list-style-type: none"> <li>1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation Inpatient care;</li> <li>2. is duly licensed by the appropriate government agency to provide such services; and</li> <li>3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission of Accreditation of Rehabilitation Facilities.</li> </ol> <p>A Rehabilitation Facility does not include institutions which provide only minimal care; custodial care; care for the terminally ill; part-time care; or services or facilities for drug abuse or alcoholism.]</p>
<b>[Related Stays</b>	Successive stays in a Hospital unless: <ol style="list-style-type: none"> <li>1. any stay after the first is necessitated by causes entirely unrelated to the causes of the earlier stay; or</li> <li>2. the stays are separated by at least {180 days}.]</li> </ol>
<b>[Schedule of Benefits</b>	A brief outline of the coverage and benefits provided by this Policy.]
<b>[Sickness</b>	A physical or mental illness [ including pregnancy]. Complications of

pregnancy are considered a Sickness.]

**[Spouse[\***

**\*The term Spouse includes a Domestic Partner as defined.]**

The [Employee] [Member]'s lawful spouse [who is aged {any Age between 18 years and under Age 70.} [ who is a United States citizen or has a permanent Alien Registration Card.] [Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed by {or divorced or legally separated from} an [Employee] [Member].]]

**[Termination Date**

The date on which insurance ends as defined later in this Policy.]

**[Totally Disabled or Total Disability**

Totally Disabled or Total Disability means [either]:

1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of: education; training; or experience; [or]
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including: eating; transferring; dressing; toileting; bathing; and continence;, without human supervision or assistance.]

**[We, Us, Our**

Catlin Insurance Company, Inc.]

**[You, Your**

The [Employee] [Member] to whom the certificate is issued.]

## ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

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### **Policy Effective Date**

The Insurance Company agrees to provide Accident Insurance Benefits described in the Policy in consideration of: the Policyholder's application; and payment of the initial premium when due. Insurance coverage for the Policyholder begins on the Policy Effective Date shown on the Policy's first page [as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied].

### **Eligibility**

[An Employee] [A Member] becomes eligible for insurance under the Policy on the date: he meets all of the requirements of one of the covered classes; and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* [and is insured under the Core Plan]. [A Spouse and Dependent Children of an eligible [Employee] [Member] become eligible for any dependent insurance provided by the Policy on the later of: the date the [Employee] [Member] becomes eligible; and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of the Policy.] [No person may be eligible for insurance under the Policy as both [an Employee] [a Member] and a Spouse or Dependent Child at the same time.]

An [Employee] [Member] whose eligible class is changed after the Effective Date of his coverage shall become eligible under the new eligible class on the [first day of the month coinciding with or next following] the date of the change.

[The [Employee] [Member] Eligibility Waiting Period may differ for current and newly covered persons. ]

### **[Effective Date for Individuals**

Insurance becomes effective for an eligible [Employee] [Member] [who applies: within {31 days} of the date he becomes eligible; [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
2. [the date][the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date][the first of the month after] We receive and accept the [Employee's] [Member's] completed enrollment form during his lifetime.]

[We may, from time to time, require the [Employee] [Member] to re-enroll using forms supplied by Us to keep his insurance in force.}]

[Insurance becomes effective for [an Employee's] [a Member's] eligible Dependent Children if the [Employee] [Member] applies: within {31 days} of the date his Dependent Children become eligible;] [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
- [2. [the date] [the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
- [3. [the date] [the first of the month after] the Dependent Child meets the definition of Spouse or Dependent Child, as applicable;]
4. [the date] [the first of the month after] We receive the [Employee's] [Member's] completed enrollment form for Spouse and Dependent Child coverage, during each Dependent Child's lifetime.]

Insurance becomes effective for an eligible [Employee] [Member] who applies and agrees to make required contributions: within {31 days} of eligibility;] [ and subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date] [the first of the month after] We receive and accept the [Employee's] [Member's] completed enrollment form and the required first premium, during his lifetime.]

[Insurance becomes effective for [an Employee's] [a Member's] eligible Dependent Children [if the [Employee] [Member] applies and agrees to make required contributions: within {31 days} of the date his Dependent Children become eligible; [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
- [2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;]
3. [the date] [the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
- [4.] [the date] [the first of the month after] the Spouse or Dependent Child meets the definition of Spouse or Dependent Child, as applicable;
- [5.] [the date] [the first of the month after] We receive and accept a completed enrollment form for Spouse and Dependent Child coverage and the required first premium, during each dependent's lifetime.]

Insurance becomes effective for a newborn Dependent Child automatically from the moment of the child's live birth. Insurance for that Dependent Child automatically ends {31 days} later unless: the [Employee] [Member] has {a Spouse or other Dependent Children} insured under the Policy; or makes a request to cover the child and pays the required initial premium, during the child's lifetime.]

**Newborn Children:** [An Employee's] [A Member's] newborn child is automatically covered from the moment of birth until such child is 90 days old if all other eligible children are covered under the certificate prior to the birth of the newborn child. Coverage for newborns shall be the same as for all other covered Dependent Children. The [Employee] [Member] must notify the Company in writing within 90 days of such birth or before the next premium due date, whichever is later, and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

**Adopted Children:** An adopted child is automatically covered for the first 60 days from the date of the [Employee] [Member] filing a petition for adoption unless the petition is denied or dismissed. Coverage for such child will be the same as for all other covered Dependent Children. The [Employee] [Member] must: notify the Company in writing within 60 days of: filing the petition for adoption; and pay the required additional premium (if any); in order to have coverage for the adopted child continue beyond such 60 day period.

#### **[DEFERRED EFFECTIVE DATE**

##### **[Active Service**

The effective date of insurance will be deferred for any [Employee] [Member] [or any eligible Spouse or Dependent Child] who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of: the date he returns to Active Service; and the date coverage would otherwise have become effective.]

##### **[Late Enrollment**

If application for insurance is not made within {31 days} of the date a person is first eligible for coverage [or a Life Status Change] [or during an Annual Re-Enrollment], the Covered Person will be considered a late enrollee. Coverage for any late enrollee will become effective on the later of: the date We approve the required evidence of insurability and receive required premium; and the date coverage would otherwise have become effective.]

##### **[Replacement Coverage**

[An Employee] [A Member] [and any Spouse and Dependent Children] who were insured under a Prior Plan and who is a member of the class of individuals eligible for coverage under this Policy on the effective date of the Policyholder under the Policy will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; and
2. the amount of coverage provided under the Policy.

If the amount of coverage otherwise provided by the Policy is greater than the amount provided under the Prior Plan, the greater amount will become effective on the {first day of the month on or after, or first day of the Policy year on or after or date] the [Employee] [Member], [Spouse or Dependent Child] returns to Active Service.]

[If [an Employee] [a Member] is required to contribute to the cost of any portion of his [or his Dependent Children's] insurance and is not in Active Service on the effective date of the Policyholder under the Policy, coverage will terminate {31 days} after the [Employee] [Member] returns to Active Service unless he submits an enrollment form and the required initial premium. If the [Employee] [Member] selects the amount of benefit for which he is required to pay premium for himself [or any Dependent Children], the amount in effect under this provision will be the lesser of: the amount provided under the Prior Plan; and the smallest amount he may select under the Policy.]

### **[Annual Re-Enrollment**

[An Employee] [A Member] currently insured under {the voluntary Accident portion of} the Policy, and a person who is eligible but has not previously enrolled, may increase or become insured for coverage under the Policy during an annual re-enrollment period as agreed to by Us and the Policyholder. [An Employee] [A Member] who is insured under the Policy may also elect or increase coverage for his eligible Dependent Children.] Coverage elected during an Annual Re-Enrollment Period will become effective [, subject to the *Active Service* section of the *Deferred Effective Date* provision,] on [the Policy Anniversary following, or first day of the month following the] date We receive a request and any required premium payment.]

### **[Life Status Change**

A Life Status Change an event that the Policyholder determines qualifies [an Employee] [a Member] to [elect,] or increase accident insurance benefits [for himself and his Spouse and Dependent Children]. [Any change in benefit elections must be made within {31 days} of a Life Status Change.]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase his accident insurance include:

- [1. marriage];
- [2. loss of a spouse, whether by death, divorce, annulment or legal separation];
- [3. birth or adoption of a child, or acquiring a child through marriage]; and
- [4. an increase in cost or a significant reduction or loss of group accident benefits provided by a Spouse's Plan].]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase accident insurance for his Spouse and eligible Dependent Children include:

- [1. marriage];
- [2. birth or adoption of a child, or acquiring a child through marriage]; and
- [3. a significant reduction, increase in cost or loss of group accident benefits provided by a Spouse's Plan].]

Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the [{first of the month following the} Life Status Change [or the {first day of the month following the} date the [Employee] [Member] applies and agrees to make required contributions]].

[The Policyholder should seek advice of its tax advisors if [Employees] [Members] may contribute to the cost of any insurance provided by the Policy with earnings not subject to Federal Income Tax. We cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward cost of insurance.]]

### **Effective Date of Changes**

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by the Policy; or
2. a change in the [Employee's] [Member's] Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

### **TERMINATION OF INSURANCE**

The insurance on a Covered Person will end on the earliest date below:

1. the date the Policy or insurance for a covered class is terminated;
- [2. the date the Policyholder's coverage under the Policy ends;]
3. the next premium due date after the date the Covered Person is no longer in a covered class or satisfies eligibility requirements under the Policy;
4. the last day of the last period for which premium is paid;
- [5. the next premium due date after the Covered Person attains the maximum Age for insurance under the Policy, as shown in the *Schedule of Benefits*;]
- [6. with respect to a Spouse {or Dependent Child}, the date of the death of the covered [or the date of divorce from the covered [Employee] [Member], unless the Spouse elects to continue insurance, including insurance on Dependent Children.] See *Continuation of Insurance* section;]
- [7. the date that the plan of benefits under which the Covered Person is covered is terminated.]

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

#### **[CONTINUATION OF INSURANCE**

Insurance for the covered Spouse [and Dependent Children] may be continued if a covered Spouse's [and Dependent Children's] insurance would otherwise end because of death of or divorce from the covered [Employee] [Member]. The Covered Spouse must:

1. submit a written request for continued insurance to Us within {31, 60, 90 days} of the event; and
2. pay the required premium to the Policyholder, directly to Us.]

[Insurance continued under this provision may not exceed the amount of insurance in force on the day before insurance as a covered Spouse ended, nor may a Spouse add any Dependent Children for insurance.]

Premiums for insurance continued under this provision will start with: the Premium Due Date on; or next following the date of the event. If a Spouse does not: elect to continue insurance under this provision; or does not provide notification within the required time period; insurance will not be continued and any premium paid from the date of the event will be refunded. [However, if notification is not given to Us within the time period required in (1.) above, any return of premium will be limited to any excess paid in the last {six, 12 months}]

Any Continuation of Insurance is subject to Our continuing to offer insurance under the Policy to new applicants.]

#### **[CONTINUATION OF INSURANCE**

We will continue insurance under the Policy for a Spouse [and Dependent Children] of a covered [Employee] [Member] who dies, without payment of premium for {12 to 24 months}. The Spouse [and Dependent Children]: (a) must have been insured under the Policy on the date the [Employee] [Member] died; and (b) must continue to meet all other requirements for eligibility. Coverage continued under this provision will terminate on the earlier of: the end of {the 12<sup>th</sup> month}; and the date the Spouse [or any Dependent Child] ceases to meet all other requirements for eligibility.

#### **[Continuation for {Layoff, Leave of Absence or Family Medical Leave}**

Insurance for [an Employee] [a Member] {and covered Dependent Children} may be continued until the earliest of the following dates if: (a) [an Employee] [a Member] is on a temporary {layoff, an approved leave of absence or an approved family medical leave}; and (b) required premium contributions are paid when due.

1. [for a layoff, [{six months} after] the end of the month in which the layoff begins;]
2. [for an approved leave of absence: [{six months after] the end of the month in which the leave begins;]
3. [for an approved family medical leave {12 weeks in a consecutive 12-month period.}]

[Such continuation will {run concurrently with, precede} a continuation during any other leave.]]

#### **[Continuation for Military Service**

If [an Employee] [a Member] begins a leave of absence to serve in the armed forces, insurance for the [Employee] [Member] {and his Covered Dependent Children} will continue until the earliest of the following dates, if the required premium is paid:

1. 18 months;
2. the day the [Employee] [Member] fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when coverage is continued under this provision:

1. [any change in benefits that occurs during the period of continuation will apply on the effective date of the change;]
2. [any Active Service requirement will be waived; ]
3. The [Employee] [Member] will be given credit for the time he was covered under the Policy prior to the leave.

If [an Employee] [a Member] does not continue coverage for himself [and his Dependent Children] during such leave and returns to [work] [membership]:

1. the [Employee] [Member] [and his Dependent Children] will be covered on the date the [Employee] [Member] returns to [work] [membership] from the leave. The [Employee] [Member] must return to [work] [membership] as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;
2. any portion of an eligibility waiting period that has not been completed will not be credited during the [Employee's] [Member's] leave.]]

## COMMON EXCLUSIONS

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In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

- [1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane];
- [2. commission or attempt to commit a felony or an assault];
- [3. commission of or active participation in: a riot; or insurrection];
- [4. {bungee jumping;}{ parachuting;}{ skydiving;}{parasailing;}{ hang-gliding}];
- [5. declared or undeclared war or act of war];
- [6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as:
  - a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
  - c. a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent;] or
- [7. flight in; boarding; or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
  - [a. except as a fare-paying passenger on a regularly scheduled commercial airline];
  - [b. being flown by the Covered Person or in which the Covered Person is a member of the crew];
  - [c. being used for:
    - [i. crop dusting; spraying or seeding; giving and receiving flying instruction; fire fighting; sky writing; sky diving or hang-gliding; pipeline or power line inspection; aerial photography or exploration; racing; endurance tests; stunt or acrobatic flying]; or
    - [ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);]
  - [d. designed for flight above or beyond the earth's atmosphere];
  - [e. an ultra-light or glider];
  - [f. being used for the purpose of parachuting or skydiving];
  - [g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;]
- [8. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle];
- [9. participation in any motorized race or contest of speed];
- [10. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program];
- [11. Sickness; disease; bodily or mental infirmity; bacterial or viral infection or medical or surgical treatment thereof; except for any bacterial infection resulting from: an accidental external cut or wound; or accidental ingestion of contaminated food];
- [12. medical or surgical treatment; diagnostic procedure; administration of anesthesia; or medical mishap or negligence, including malpractice];
- [13. travel or activity outside the United States or Canada];
- [14. travel in any Aircraft owned; leased; or controlled by the Policyholder; or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year];
- [15. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred];
- [16. voluntary ingestion of any narcotic; drug; poison; gas; or fumes; unless: prescribed or taken under the direction of a Physician; and taken in accordance with the prescribed dosage];
- [17. injuries compensable under: Workers' Compensation law; or any similar law];
- [18. occupational injuries for which benefits are not paid under: the Workers' Compensation Law; or any similar law];
- [19. injuries that result from a non-occupational accident];
- [20. a Covered Accident that occurs while on active duty service in: the military; naval; or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days];

In addition, benefits will not be paid for:

- [21. services or treatment rendered by: a Physician; Nurse; or any other person who is:
  - a. employed or retained by the Policyholder;
  - b. providing: homeopathic; aroma-therapeutic; or herbal therapeutic services;
  - c. living in the Covered Person's household;
  - d. who is: a parent; sibling;, spouse; or child of the Covered Person];
- [22. any Hospital Stay or days of a Hospital Stay that are not appropriate for the condition and locality.]

## [CONVERSION PRIVILEGE]

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- [1. If the Covered Person's insurance or any portion of it ends for a reason other than: non-payment of premium; the Covered Person's Age; or those reasons described in Paragraph 2 below; the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated policy. The Covered Person may not apply for an amount greater than his coverage under this Policy [less the amount of any other group accident insurance for which he becomes eligible within 31 days after the date coverage under this Policy terminated.] The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

The Covered Person must apply for the individual policy within 31 days after his coverage under this Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk.

The individual policy or certificate will take effect on the day following the date coverage under the Policy ended. If the Covered Person dies during this 31-day period as the result of an accident that would have been covered under this Policy, We will pay as a claim under this Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Policy.

2. If the Covered Person's insurance ends because this Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Policy for at least five years, the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
- a. coverage under this Policy less any amount of group accident insurance: for which he is eligible on the date this Policy is terminated; or for which he became eligible within 31 days of such termination; or
  - b. {\$10,000}

## CLAIM PROVISIONS

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### **Notice of Claim**

Written {or authorized electronic/telephonic} notice of claim must be given to Us: within {31 days} after a Covered Loss occurs or begins; or as soon as reasonably possible. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given to Us: at Our Home Office in Houston, Texas; or such other place as We may designate for the purpose; or to Our authorized agent. Notice should include: the Policyholder's name and policy number; and the Covered Person's name; address; policy; and certificate number.

### **Claim Forms**

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written {or authorized electronic} proof of the nature and extent of the loss for which the claim is made.

### **[Claimant Cooperation Provision**

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

### **Proof of Loss**

Written {or authorized electronic} proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss; then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written {or authorized electronic} notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written {or authorized electronic} proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

[The Plan Administrator of the Policyholder's employee welfare benefit plan (the Plan) has selected the Insurance Company as the Plan fiduciary under federal law for the review of claims for benefits provided by the Policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion: to interpret the terms of the Plan documents; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by the Insurance Company in this capacity shall be final and binding on Participants and Beneficiaries of The Plan to the full extent permitted by law.]

The Insurance Company has no fiduciary responsibility with respect to the administration of The Plan except as described above. It is understood that the Insurance Company's sole liability to the Plan and to Participants and Beneficiaries under The Plan shall be for the payment of benefits provided under the Policy.]

### **Time of Payment of Claims**

We will pay benefits due under the Policy for any loss other than a loss for which the Policy provides any periodic payment immediately upon receipt of due written {or authorized electronic} proof of such loss. Subject to due written {or authorized electronic} proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid no later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

### **Payment of Claims**

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under the Policy, unless otherwise stated, will be payable to the covered [Employee] [Member], his estate, or the hospital or person rendering services upon request by the group Policyholder.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay {\$1,000 - \$5,000} to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability, unless, before payment is made, We have received at Our home office written notice by or on behalf of another person that the other person claims to be entitled to the payment or some interest in the Policy.

#### **[Payment of Claims to Foreign [Employees] [Members]**

The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered [Employees] [Members] whose place of [employment] [membership] is other than:

- {1. the United States of America;}
- {2. Puerto Rico; or}
- {3. the Dominion of Canada}.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under the Policy.]

#### **Physical Examination [and Autopsy]**

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

#### **Legal Actions**

No action at law or in equity may be brought to recover under the Policy less than 60 days after written {or authorized electronic} proof of loss has been furnished as required by the Policy. No such action will be brought more than three years after the time such [written proof of loss must be furnished.

#### **Beneficiary**

The beneficiary is the person or persons the [Employee] [Member] names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary [, or to make any assignment of rights or benefits permitted by the Policy.] [A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child.] [Any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child will be paid to the [Employee's] [Member's] estate.]

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the [Employee] [Member] has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the [Employee] [Member] dies while benefits are payable to him, We may make direct payment to [the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of the [Employee] [Member].]

Or

[the estate of the [Employee] [Member].]

**Recovery of Overpayment**

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount;
2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

## ADMINISTRATIVE PROVISIONS

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### Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for the Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. [If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day before the reduction took place.]

### Changes in Premium Rates

We may change the premium rates from time to time with at least {31 days} advance written notice to the Policyholder. No change in rates will be made until {12 months} after the Policy Effective Date. An increase in rates will not be made more often than once in {a 12-month period}. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of the Policy change;
- [2. the terms of the Policyholder's participation change;]
- [3.] a division, subsidiary, affiliated company or eligible class is added or deleted from the Policy;
- [4.] there is a change in the factors bearing on the risk assumed;
- [5.] any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

### Payment of Premium

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder.

If any premium is not paid on the Premium Due Date when due, the Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period section.

### Grace Period

[1.] {Policy}

A Policy Grace Period of {31 days} will be granted for payment of required premiums under the Policy. The Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time the Policy was in force.

[2. {Covered Person}

A Grace Period of {31 days} will be granted for payment of required premiums under the Policy. A Covered Person's insurance under the Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If: no such claims are incurred; and premium is not paid during the grace period; insurance will end on the last day of the period for which premiums were paid.]

## GENERAL PROVISIONS

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### **Entire Contract; Changes**

The Policy, including: the endorsements; amendments; and any attached papers; constitutes the entire contract of insurance. No change in the Policy will be valid until: approved by one of Our executive officers; and endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

### **Misstatement of Fact**

If the Covered Person has misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased had such fact been correctly stated.

### **Certificates**

Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list: the benefits; conditions; and limits of the Policy. It will state to whom benefits will be paid.

### **Multiple Certificates**

The Covered Person may have in force only one certificate at a time under the Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

[A Covered Person is not eligible for insurance under more than {one certificate providing benefits for accident insurance under group policies issued by Us}. If premium is being paid for more than one such certificate, insurance will be in effect under the certificate with the earliest effective date and premiums paid for certificates which are not in effect will be refunded.]]

### **Assignment**

*Option 1: Include if no rights and benefits are assignable:*

[The rights and benefits under the Policy may not be assigned and any attempt to assign will be void.]

*Option 2: Include when no assignment other than benefits that have become payable is permitted:*

[The rights and benefits provided by the Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.]

*Option 3: Include if assignment is permissible:*

[We will be bound by an assignment of a Covered Person's insurance under the Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while: the assignment remains in effect; and insurance under the Policy and the Covered Person's certificate remains in force. We will deal with the assignee as the owner or pledge of the Policy in accordance with the terms of the assignment until We have received at Our home office written notice of termination of the assignment or written notice by or on behalf of some other person claiming some interest in the Policy in conflict with the assignment.]

### **Incontestability**

1. Of The Policy or Participation Under The Policy  
All statements made by the Policyholder to obtain the Policy are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; or to deny the validity of the Policy or of participation under the Policy; unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause the Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from: the Covered Person's effective date of insurance; or from the effective date of increased benefits; no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

### **[Reporting Requirements**

The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. additional information required by Us.]

### **Policy Termination**

We may terminate coverage on or after [the first anniversary of the policy effective date]. The Policyholder may terminate coverage on any premium due date. Written {or authorized electronic} notice must be given at least {31 days} prior to such premium due date. [Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

### **[Reinstatement**

The Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are: written application of the Policyholder satisfactory to Us; and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid [, but not to any period more than {60 days} prior to the date of reinstatement.]]

### **Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such error or delay is found, We will adjust the premium fairly.

### **Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that apply to the Policy are automatically changed to satisfy the minimum requirements of such laws.

### **Policy Changes**

We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

### **Workers' Compensation Insurance**

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

### **Examination of the Policy**

This Policy will be available for inspection at the Policyholder's office during regular business hours.

### **Examination of Records**

We will be permitted to examine all of the Policyholder's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

## DESCRIPTION OF [COVERAGES] AND BENEFITS

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This Description of [Coverages and] Benefits Section describes the Accident [Coverages and] Benefits provided by the Policy. Benefit amounts; benefit periods; and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within the Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms; conditions; and limitations applicable to these [coverages and] benefits.

### [ACCIDENTAL DEATH BENEFIT

- Covered Loss** We will pay the benefit shown in the *Schedule of Benefits* if {a Covered Person} dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].
- Exclusions** Exclusions that apply to this Benefit are specified in *Common Exclusions* Section.]

## [ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

### **Covered Loss**

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if {the Covered Person} suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].

[If {the Covered Person} sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable.] If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

### **Definitions**

[**Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.]

[**Loss of Sight** means the total, permanent loss of all vision in one eye which is irrecoverable by: natural; surgical; or artificial means.]

[**Loss of Speech** means total and permanent loss of audible communication which is irrecoverable by: natural; surgical; or artificial means.]

[**Loss of Hearing** means total and permanent loss of ability to hear any sound {in both ears} which is irrecoverable by: natural; surgical; or artificial means.]

[**Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand** means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).]

[**Loss of Toes** means complete Severance through the metatarsalphalangeal joint.]

[**Paralysis or Paralyzed** means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.]

[**Quadriplegia** means total Paralysis of both upper and both lower limbs.]

[**Hemiplegia** means total Paralysis of the upper and lower limbs on one side of the body.]

[**Paraplegia** means total Paralysis of both lower limbs or both upper limbs.]

[**Uniplegia** means total Paralysis of one upper or one lower limb.]

[**Coma** means a profound state of unconsciousness: which resulted directly and independently from all other causes from a Covered Accident;

and from which {the Covered Person} is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.]

**[Severance** means the complete and permanent separation and dismemberment of the part from the body.]

**Exclusions**

The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

### **[ADDITIONAL [ACCIDENTAL DEATH AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other {Accidental Death and Dismemberment} benefits payable.]

### **[ARMED FORCES COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if {the Covered Person} suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while he is on active duty in any Armed Forces.

**Exclusions**                      The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### **[EXPOSURE AND DISAPPEARANCE COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if {a Covered Person} suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If {the Covered Person} disappears and is not found within {one year} from the date of: the wrecking; sinking; or disappearance of the conveyance in which {the Covered Person} was riding in the course of a trip which would otherwise be covered under the Policy, it will be presumed that {the Covered Person's} death resulted directly and independently of all other causes from a Covered Accident.

**Exclusions**                      The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### **[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable subject to the following conditions if {the Covered Person} suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while {the Covered Person} is a member of the U.S. Military Reserve or National Guard.

While the Covered Person is a member of the U.S. Military Reserve or National Guard, coverage under the Policy will remain in force beyond the 31-day active duty training period and continue:

1.            during the Covered Person's initial training period;
2.            if the Covered Person is called to active duty [for a domestic emergency].

**Exclusions**                      The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### **[OWNED AIRCRAFT COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs: during travel or flight in; including getting in or out of; any Aircraft that is: owned; leased; operated; or controlled by the Policyholder {or its subsidiaries or affiliates}. A record of eligible Aircraft will be maintained by the Policyholder and

available for review by Us at any time during normal business hours. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to: breakdown; repair; servicing; loss; or destruction.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### [PILOT COVERAGE

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while: the Covered Person is flying as a licensed pilot [or member of the crew] of an Aircraft; and meets all of the following requirements:

- [1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by Us;]
- [2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by Us;]
- [3. completes and maintains a combined minimum of {200 hours} of military, private or professional logged flight hours;]
- [4. is flying as a pilot [or member of the crew] of an Aircraft traveling on or transacting business for the Policyholder . All trips must have been authorized in advance by the Policyholder;]
- [5. is flying as a pilot [or member of the crew] of an Aircraft [described below] or [on a list of eligible Aircraft maintained by the Policyholder, including a substitute Aircraft with no greater seating capacity while a [specified] or [listed] Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction;]
- [6. is flying as a pilot [or member of the crew] of an Aircraft that is [not] owned, leased, operated or controlled by the Policyholder;]
- [7. is not giving or receiving flight instruction.]

**[Description of Aircraft Covered** {xxxx will list: type of Aircraft; license number; and passenger seating capacity: Boeing 727; License # PA12345; passenger seating capacity: 45}]

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### [WAR RISK COVERAGE

Benefits for {Accidental Death and Dismemberment} as shown in the *Schedule of Covered Losses*, will be payable, subject to the following conditions and exclusions, if a Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during war or acts of war that occur in:

- {1. a specifically described geographic area such as Saudi Arabia, Iran, Serbia}; or
- {2. a generally described geographic area such as worldwide, excluding the United States and its territories and possessions.}

The Policyholder may cancel this war risk coverage at any time by sending written notice to Us at Our home office address. Coverage will be canceled upon receipt of notice or a date specified by the Policyholder.

We may cancel this coverage at any time by providing written notice to the Policyholder at least {10 days} prior to termination of this coverage. Any unearned premium will be promptly returned to the Policyholder.

**Exclusions** This benefit does not provide coverage when a Covered Loss occurs:  
[1. in the United States and its territories and possessions; or]  
[2. in any nation of which the Covered Person is a citizen.]

[[Other} exclusions that apply to this coverage are in the *Common Exclusions* Section.]]

**[ADDITIONAL ACCIDENT BENEFITS]**

[{Accidental Death and Dismemberment benefits} are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other {Accidental Death and Dismemberment benefit} payable.]

**[ADDITIONAL OCCUPATIONAL BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss which results directly and independently of all other causes from a Covered Accident that occurs while the covered [Employee] [Member] is on the Policyholder's premises and engaged in the course of his [job] [membership] [or on business travel pre-authorized by the Policyholder].

[Business travel begins at the actual start of a business trip that has been pre-authorized by the Policyholder, whether the trip starts at the covered [Employee's] [Member's]: home; place of work; or another place. Business travel coverage:

1. ends when the covered [Employee] [Member] arrives at his: home; or place of work; whichever happens first; and
2. is not in effect during the covered [Employee's] [Member's] Personal Deviation.]

[Business travel includes: riding in; or getting on or off of; an Aircraft, but only if:

1. the covered [Employee] [Member] is riding as a passenger only, and not as a pilot or member of the crew; and
2. the Aircraft is not being used for any of the following:
  - a. crop dusting, spraying or seeding;
  - b. fire fighting;
  - c. sky writing;
  - d. sky diving or hang gliding;
  - e. pipeline or power line inspection;
  - f. aerial photography or exploration;
  - g. racing;
  - h. endurance tests, stunt or acrobatic flying;
  - i. any operation which requires a special permit from the FAA, even if it is granted unless the permit is required only because of the territory flown over or landed on;
  - j. giving or receiving flying instruction.]

**Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs: prior to the end of the trip; [or within {one hour } before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]

- Exclusions** [Business travel coverage is not provided during:
1. normal commuting between the covered [Employee's] [Member's] home and place of work; or
  2. the covered [Employee's] [Member's] Personal Deviation {in excess of 30 days}.]
- [{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT**

We will pay counseling sessions, up to the Maximum Benefit Amount shown in the *Schedule of Benefits* and subject to the following conditions and exclusions, when the Covered Person{and/or Immediate Family Member} requires bereavement and trauma counseling because the Covered Person suffered a Covered Loss that resulted directly and independently of all other causes from a Covered Accident. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within {one year} from [the date of the Covered Accident causing the Covered Loss];
2. the expense is charged for a bereavement or trauma counseling session for the Covered Person{and/or one or more of his Immediate Family Members};
3. counseling is provided under the care, supervision or order of a Physician;
4. a charge would have been made if no insurance existed.

**Definitions** For purposes of this benefit:  
**Immediate Family Member** means a person who is related to the Covered Person in any of the following ways: Spouse; brother-in-law; sister-in-law; son-in-law; daughter-in-law; mother-in-law; father-in-law; parent (includes stepparent); brother or sister (includes stepbrother or stepsister); or child (includes legally adopted child or stepchild).

**Exclusions** Covered bereavement and trauma counseling benefits do not include any expense for which the Covered Person is entitled to benefits under any Workers' Compensation Act or similar law.

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BOMB SCARE, BOMB SEARCH OR BOMB EXPLOSION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. the covered [Employee] [Member] is on the Policyholder's premises when the Covered Accident occurs;
2. the Covered Accident is caused by or results from a Bomb Scare, Search or Explosion, as defined below;
3. the covered [Employee] [Member] is an authorized participant of a team or squad engaged in a Bomb Search or related activity;
4. the Policyholder authorizes the covered [Employee's] [Member's] participation and sanctions the search.

**Definitions** For purposes of this benefit:  
**Bomb** means any real or dummy explosive device placed with intent to: damage; scare; or cause injury.

**Scare** means any real or false report of a Bomb on the premises of the Policyholder.

**Search** means any organized search for a reported Bomb.

**Explosion** means any detonation of a Bomb on the Policyholder's premises which appears to have been intended to cause injury or unlawful property damage, whether or not the presence of the Bomb was reported before detonation. [It does not include: any act of declared or undeclared war in the United States of America or Canada; or acceptance of known explosives as cargo.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section. ]

#### **[BULLETPROOF VEST BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] {who is Age 18 or older} is on official duty for the Policyholder and is shot during a Covered Accident while wearing a Bulletproof Vest and:

1. the Bulletproof Vest fails to prevent the bullet's penetration through the vest; and
2. such penetration results, directly and independently of all other causes, in {a Covered Loss, Covered Injury}.

**Definition** For purposes of this benefit:

**Bulletproof Vest** means a protective vest designated as { Threat Level II-A; Threat Level II; or Threat Level III-A} [manufactured by a vendor designated by the Policyholder] and [purchased not more than {five years} before the Covered Accident.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[BURIAL AND CREMATION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, for burial or cremation of the covered [Employee] [Member] who dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[BUSINESS TRAVEL BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a business trip authorized in advance by the Policyholder. The Covered Loss must be sustained:

1. in the course of the covered [Employee's] [Member's] [job] [membership];
- [2. away from the premises of the Policyholder in the covered [Employee's] [Member's] city of permanent assignment].

Coverage will begin at the actual start of a business trip authorized by the Policyholder. It does not matter if the trip starts at the covered [Employee's] [Member's]: home; place of work; or any other place. Coverage will end when the covered [Employee] [Member] arrives at: his home; or place of work; whichever happens first.

**[Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs prior to the end of the trip [or within {one hour} before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]]

**Exclusions** Coverage for business travel is not provided during [any of the following]:

1. normal commuting between the covered [Employee's] [Member's] home and place of work;
- [2. travel in an Aircraft: owned; leased; operated; or controlled by the Policyholder;]
3. travel to another location where the [Employee] [Member] is expected to be assigned for more than {60 days} by the Policyholder;
4. a covered [Employee's] [Member's] Personal Deviation [in excess of {31 days}].

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[CHILD CARE CENTER BENEFIT**

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered [Employee] [Member] [Spouse] results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. coverage for his Dependent Children was in force on the date of the Covered Accident causing his death: and
2. one or more surviving Dependent Children is under Age {13}; and
  - [a. was enrolled in a Child Care Center on the date of the Covered Accident; or]
  - [b. enrolls in a Child Care Center within {90 - 365 days} from the date of the Covered Accident].

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each {12 month} period that begins after the date of the covered [Employee's] [Member's] [Spouse's] death. A claim must be submitted to Us at the end of each {12 month} period [with proof of enrollment and attendance]. A {12 month} period begins:

- [1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered [Employee's] [Member's] [Spouse's] death; or]
2. on the first of the month following the covered [Employee's] [Member's] [Spouse's] death, if the Dependent Child was enrolled in a Child Care Center before the covered [Employee's] [Member's] [Spouse's] death.

Each succeeding {12 month} period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

**Definitions** For purposes of this benefit:

**Child Care Center** is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

[**Surviving Spouse** will include the covered [Employee] [Member] and covered Spouse.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[COMMON CARRIER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Common Carrier** means:

1. a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or a similar air transport service of another country.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[EMERGENCY ROOM BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Emergency Room Treatment due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Definition** For purposes of this benefit:

**Emergency Room** means a trauma center or a special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[ESCALATOR BENEFIT**

We will increase the Covered Person's Principal Sum by {the dollar amount or the percentage of Principal Sum} shown on the *Schedule of Benefits*, subject to the following conditions and exclusions. [The Covered Person must be under Age {55; 60} to be eligible for this benefit.] [Benefit amounts for {a covered Spouse, Dependent Child} will not be increased.]

[The Principal Sum used to calculate this benefit:

1. will be the amount in force when the Covered Person first becomes insured for this benefit;
2. will not compound previous Escalator benefit amounts.]

Increases will become effective on each {Policy or certificate anniversary} after the Covered Person has been insured for {12 consecutive months}. Benefit increases will occur automatically at the end of each {12 month} period, for a maximum of {five years}.

[Increases provided by this benefit will be calculated separately for each additional Principal Sum the Covered Person elects. The total amount of all increases will not exceed the highest amount shown in the *Schedule of Benefits*.

[If the Covered Person's Principal Sum is reduced, any increases provided under this benefit will be reduced in the same proportion.]

**Exclusions** [This benefit will not apply to any *Bonus Benefit*.]

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT**

We will pay the amount shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault as described below. [A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid.] [The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder.]

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

[We will pay a Hospital Stay Benefit, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

- [1. the Covered Person is covered for Hospital Stay benefits under the Policy;]
2. the Hospital Stay begins within {30 days} of the violent crime/felonious assault;
- [3. the Hospital Stay is at the direction and under the care of a Physician;]
4. the Covered Person provides proof satisfactory to Us that his Hospital Stay was necessitated to treat Covered Injuries sustained in a Covered Accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Definitions** For purposes of this benefit:

**Family Member** means the Covered Person's parent; step-parent; Spouse; or former Spouse; son; daughter; brother; sister; mother-in-law; father-in-law; son-in-law; daughter-in-law; brother-in-law; sister-in-law; aunt; uncle; cousins; grandparent; grandchild; and stepchild.

**Fellow [Employee] [Member]** means [a person employed by] [a member of] the same Policyholder as the Covered Person or by an Entity that is an affiliated or subsidiary entity. It shall also include any person who was so [employed] [qualified as a member], but whose [employment] [membership] was terminated not more than {45 days} prior to the date on which the defined violent crime/felonious assault was committed.

**Member of the Same Household** means a person who maintains residence at the same address as the Covered Person.

**Exclusions** Benefits will not be paid for treatment of any Covered Injury sustained or Covered Loss incurred during any:

1. violent crime or felonious assault committed by the Covered Person; or
2. felonious assault or violent crime committed upon the Covered Person by: a Fellow [Employee] [Member]; Family Member; or Member of the Same Household.

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[HIV OCCUPATIONAL ACCIDENT BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the covered [Employee] [Member] suffers a Covered Injury resulting, directly and independently of all other causes, from a Covered Accident. Such Covered Accident must: occur during the performance of Occupational Duties; and result in the covered [Employee] [Member] acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within {one year} of the Covered Injury.

In order to receive this benefit, the covered [Employee] [Member] must satisfy all of the following:

1. submit a Workers' Compensation Injury report to the Policyholder, within {48 hours} of the Covered Accident that occurs during the performance of Occupational Duties;
2. test negative for Human Immunodeficiency Virus (HIV) antibodies within {48 hours} of such Covered Accident;
3. test positive for Human Immunodeficiency Virus (HIV) antibodies in a subsequent Blood Test within {one year} of the date of the Covered Accident.

**Definitions** For purposes of this benefit:

**Occupational Duties** means the performance of normal work duties on behalf of the Policyholder.

**HIV** means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

**Blood Test** means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by Us.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay the Covered Home Alteration and Vehicle Modification Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss, other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. the Covered Person requires home alteration or vehicle modification within {one year} of the date of the Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOSPITAL STAY BENEFIT**

We will pay the {daily, monthly} benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires a Hospital Stay due to {a Covered Loss} resulting directly and independently of all other causes from a Covered Accident.

The Hospital Stay must meet all of the following:

1. be at the direction and under the care of a Physician;
2. begin within {30 days} of the Covered Accident;
- [3. begin while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay that continues after the end of the Benefit Waiting Period as shown in the *Schedule of Benefits*. Benefits will be paid retroactively to the first day of the Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[PRIVATE PASSENGER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident while: driving; riding as a passenger in; or getting in or out of; a Private Passenger Automobile.

*Include if Accidental Death and Dismemberment Benefits are not included in the issued policy.*

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Private Passenger Automobile** means a validly registered; four wheel private passenger car (including Policyholder-owned cars); campers; motorized golf carts; motor homes; non-motorized bicycles; non-motorized adult tricycles; station wagons; sport utility vehicles; pick-up trucks; and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a: taxicab; bus; or other public conveyance will not be considered a Private Passenger Automobile.

Any vehicle not defined above will not be considered a Private Passenger Automobile.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[REHABILITATION BENEFIT**

We will pay the Rehabilitation Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person requires rehabilitation after sustaining a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Covered Person must require Rehabilitation within {two years} after the date of {the Covered Accident, Covered Loss}.

**Definition** For purposes of this benefit:

**Rehabilitation** means {medical services; supplies; or treatment; or Hospital confinement (or part of a Hospital confinement)} that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the Covered Person's Covered Loss;
2. meet generally accepted standards of medical practice;
3. are performed under: the care; supervision; or order of a Physician;
4. prepare the Covered Person to return to his or any other occupation.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[SEATBELT [AND AIRBAG] BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a

passenger in an Automobile. [An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).]

Verification of proper use of the seatbelt at the time of the Covered Accident [and that the Supplemental Restraint System properly inflated upon impact] must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

[If: such certification or police report is not available; or it is unclear whether the Covered Person was wearing a seatbelt [or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System]; We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.]

[In the case of a child, seatbelt means: a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration; properly secured; and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.]

**Definitions** For purposes of this benefit:  
[if airbag benefit is included: **Supplemental Restraint System** means an airbag that inflates upon impact for added protection to the head and chest areas.]

**Automobile** means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to: a sedan; station wagon; sport utility vehicle; or a motor vehicle of the pickup; van; camper; or motor-home type. Automobile does not include: a mobile home; or any motor vehicle which is used in mass or public transit.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[SPECIAL EDUCATION BENEFIT**

We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for [each qualifying Dependent Child] [and][a surviving covered Spouse] who {is/are} insured under the covered [Employee's] [Member's] certificate on the date he dies {or if he has been Totally Disabled during the Benefit Waiting Period for Permanent Total Disability benefits.} The [Employee's] [Member's] death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit [or Permanent Total Disability Benefits] {is, are} payable under the Policy. This benefit is subject to the conditions and exclusions described below.

[A qualifying Dependent Child must:

1. a. [be enrolled as a full-time student in an accredited school of higher learning beyond the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident]; *or*  
b. [be at the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident and then enroll as a full-time student at an accredited school of higher learning within {365 days} from the date of the Covered Accident and continue his education as a full-time student.]
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for: tuition; fees; books; room and board;,, transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in the Policy;

2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying surviving Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in the Policy;
2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying surviving Spouse must:

1. enroll in any accredited school for the purpose of retraining or refreshing skills needed for employment within {one year} of the date of the covered [Employee's] [Member's] Covered Accident;
2. remain enrolled in such accredited school; and
3. incur expenses: payable directly to; or approved by; such school.]]

Payments will be made to each qualifying Dependent Child [or to the child's legal guardian, if the child is a minor] at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits], if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

[If no Dependent Child qualifies for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

[Payments will be made to the surviving Spouse at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Spouse's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the date the surviving Spouse enrolls in an accredited school for the first time following the date the [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits]. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.]]

[If a surviving Spouse does not qualify for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[TOTAL DISABILITY WEEKLY INCOME BENEFIT**

We will pay weekly benefits shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, to the Covered Person whose Total Disability results: directly and independently of all other causes from; and within {31 days} of; a Covered Accident. Weekly disability benefits will begin when the Totally Disabled Covered Person satisfies the Benefit Waiting Period shown in the *Schedule of Benefits* and will end on the earliest of the date he:

1. dies;
2. is no longer Totally Disabled;
3. fails to provide certification by a Physician that he remains Totally Disabled;

4. is eligible to receive [Accidental Death and Dismemberment benefits] [Permanent Total Disability benefits] for the same Covered Accident];
5. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits*.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[WAIVER OF PREMIUM BENEFIT**

We will waive premiums, beginning with those due on and after the end of the Benefit Waiting Period, for a covered [Employee] [Member] {and}{Spouse} who:

- a. becomes Totally Disabled [within {30 days} of] [after suffering] a Covered Loss that results directly and independently of all other causes from a Covered Accident; and
- b. satisfies all of the following conditions:
  1. Total Disability must begin before the covered [Employee's] [Member's] {Spouse's} {60th} birthday;
  2. We must receive proof satisfactory to Us that Total Disability was continuous during the Benefit Waiting Period;
  3. insurance under the Policy remains in force during the Benefit Waiting Period.

The covered [Employee] [Member] must submit satisfactory proof of continuous Total Disability to Us no more than {three to 12 months} after the date he [became Totally Disabled] [satisfies the Benefit Waiting Period]. Proof of continuing Total Disability must be submitted to Us during the last {three months} of each year. We may have the covered [Employee] [Member] {Spouse} examined as often as reasonably necessary while Totally Disabled, but not more than once a year after two years.

The amount of insurance for which premiums will be waived is the amount in force on the date the covered [Employee] [Member] {Spouse} became Totally Disabled. This amount will be subject to any age reductions applicable during the Benefit Period. Any increases in coverage that would have occurred if the covered [Employee] [Member] {Spouse} were not Totally Disabled will be deferred, as described in the *Deferred Effective Dates* provision of the *Eligibility and Effective Date* section of the Policy.

Premiums will cease to be waived on the earliest of the following dates:

1. the premium due date following the date the covered [Employee] [Member] {Spouse} ceases to be Totally Disabled;
2. the date the covered [Employee] [Member] {Spouse} refuses to be examined or fails to provide required proof of continuing Total Disability;
3. the premium due date following the end of the Benefit Period shown in the *Schedule of Benefits*.

When premiums cease to be waived as described above, insurance provided under the Policy will continue as long as premiums are paid when due.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**CATLIN INSURANCE COMPANY, INC.**

Home Statutory Office: 1330 Post Oak Boulevard, Suite 2325 • Houston, Texas 77056  
Administrative Office: 3340 Peachtree Road N.E., Suite 2950 • Atlanta, Georgia 30326  
1-877-CATLIN-US (1-877-228-5468)

(a Stock Insurance Company, hereafter called "the Company")

**Arkansas Application for Group Accident Insurance**

**Part 1— Applicant Information**

Name of Applicant \_\_\_\_\_  
(legal name of entity)

DBA (if applicable) \_\_\_\_\_

Nature of Entity \_\_\_\_\_ SIC Code \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Desired Effective Date: \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Applicant is a:    Corporation    Partnership    Sole Proprietorship    Other \_\_\_\_\_

Are [Employees] [Members] of any affiliate or subsidiary entities to be covered?    Yes    No  
(If yes, please complete the following for each such affiliate/subsidiary. Attach separate sheet if needed.):

Name	Address	Total [Employees] [Members]	Nature of Entity	SIC Code

**Part 2—Participants and Eligibility**

Persons eligible to be covered under the Policy are:

- Full-time Employees (working at least [20 – 40] \_\_\_\_\_ hours per week),
- Other: \_\_\_\_\_

,provided that a written application/enrollment has been made and the required premium paid in accordance with the terms of the Policy.

Class	Description of Classes
1	[All full-time Employees of the Policyholder working at least [20-40] hours per week]
2	[All part-time Employees of the Policyholder working at least [0-40] hours per week]
3	[All active Members of the Policyholder]
4	[All Spouses and Dependent Children of Class 1, 2, or 3]

Any additional classes should be added on the back of this application.

Dependent Children of members of these eligible classes may also be eligible, provided the Dependent Child insurance option in this application is elected by the Applicant, the Policy's requirements for Dependent Child eligibility and enrollment are met, and the correct premium is paid.

Total number of Employees on payroll \_\_\_\_\_ Full-time \_\_\_\_\_ Number eligible for coverage \_\_\_\_\_

WAITING PERIOD:

Initial Group:  None  \_\_\_ Days  \_\_\_ Months  Other \_\_\_\_\_  
 New Enrollees:  None  \_\_\_ Days  \_\_\_ Months  Other \_\_\_\_\_

CONTRIBUTIONS:	Premium Percentage Payable	
	Policyholder	[Employee] [Member]
Class I	[100] %	[0] %
Class II	[0] %	[100] %
Class III	[0] %	[100] %
Class IV	[0] %	[100] %

(If Policyholder pays 100% for any class of participants, all members of that class must be enrolled. Other minimum participation requirements apply.)

**[Part 3—Benefit Options**

- Accidental Death for [Employees] [Members]\*\*†:**  
(Select one option from table below for each eligible class):

Option A—Multiples of annual salary rounded to next highest [\$1,000.00]  
 Option B—Level amount  
 Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Salary Multiplier Maximum [ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Maximum Amount: \$	Option B Level Amount Maximum \$	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I							\$
II							\$
III							\$

- Accidental Death and Dismemberment Insurance for [Employees] [Members]\*\*†:**  
(Select one option from table below for each eligible class):

Option A—Multiples of annual salary rounded to next highest [\$1,000.00]  
 Option B—Level amount  
 Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Salary Multiplier Maximum [ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Maximum Amount: \$	Option B Level Amount Maximum \$	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I							\$
II							\$
III							\$

**Spouse [& Domestic Partner] Option†:**

(Select one option from table below for each eligible class):

Option A—Percentage of [Employee's] [Member's] Principal Sum

Option B—Level amount

Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Percentage of [Employee's] [Member's] Principal Sum	Option B Level Amount Maximum	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I				%	[\$]	[\$]	[\$]
I				% with Dependent Children	[NA]	[NA]	[NA]
I				% without Dependent Children	[NA]	[NA]	[NA]
II				%	[\$]	[\$]	[\$]
II				% with Dependent Children	[NA]	[NA]	[NA]
II				% without Dependent Children	[NA]	[NA]	[NA]
III				%	[\$]	[\$]	[\$]
III				% with Dependent Children	[NA]	[NA]	[NA]
III				% without Dependent Children	[NA]	[NA]	[NA]

**Dependent Children Option†:**

(Select one option from table below for each eligible class):

Option A—Percentage of [Employee's] [Member's] Principal Sum

Option B—Level amount

Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Percentage of [Employee's] [Member's] Principal Sum	Option B Level Amount Maximum	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I				%	[\$]	[\$]	[\$]
I				% with Spouse	[NA]	[NA]	[NA]
I				% without Spouse	[NA]	[NA]	[NA]
II				%	[\$]	[\$]	[\$]
II				% with Spouse	[NA]	[NA]	[NA]
II				% without Spouse	[NA]	[NA]	[NA]
III				%	[\$]	[\$]	[\$]
III				% with Spouse	[NA]	[NA]	[NA]
III				% without Spouse	[NA]	[NA]	[NA]

\* All insurance is subject to age-based reduction schedule:

† Medical underwriting of applicants is required for certain amounts of insurance.

**Additional Accidental Death [and Dismemberment] Coverage:**

Armed Forces Coverage: Yes No

Exposure and Disappearance Coverage: Yes No  
National Guard and Armed Forces Reserve Coverage: Yes No  
Owned Aircraft Coverage: Yes No  
Pilot Coverage: Yes No  
War Risk Coverage: Yes No

**Additional Accident Benefits:**

Additional Occupational Benefit: Yes No  
Bereavement and Trauma Counseling Benefit: Yes No  
Bomb Scare, Bomb Search, or Bomb Explosion Benefit : Yes No  
Bulletproof Vest Benefit: Yes No  
Burial and Cremation Benefit: Yes No  
Child Care Center Benefit: Yes No  
Common Carrier Benefit: Yes No  
Emergency Room Benefit: Yes No  
Escalator Benefit: Yes No  
Felonious Assault and Violent Crime Benefit: Yes No  
HIV Occupational Accident Benefit: Yes No  
Home Alteration and Vehicle Modification Benefit: Yes No  
Hospital Stay Benefit: Yes No  
Private Passenger Benefit: Yes No  
Rehabilitation Benefit: Yes No  
Seatbelt [and Airbag] Benefit: Yes No  
Special Education Benefit: Yes No  
Total Disability Weekly Income Benefit: Yes No  
Waiver of Premium Benefit: Yes No

]

**Part 4—Disclosures; Applicant’s Acceptance of Terms**

Any insurance provided pursuant to this Application shall be subject to all terms and conditions of the Policy issued. It is understood and agreed that only officers of the Company—*not your insurance broker*—are authorized to change, enlarge, vary or waive any requirements of the Policy. No such change, enlargement, variance or waiver shall be valid unless made a part of the Policy by amendment or other written agreement.

If any [Employee] [Member] (or Spouse [and Domestic Partner] or Dependent if coverage elected) is not in Active Service on the date his coverage is scheduled to become effective, his coverage shall not take effect until he returns to Active Service.

***Applicant understands that no insurance shall take effect until all underwriting requirements of the Company have been met. It is further understood that any insurance provided shall take effect on the effective date approved by the Company, and that Applicant should not cancel any predecessor policy or plan until notified by the Company that this Application has been approved.***

Dated at \_\_\_\_\_ (city, state) on \_\_\_\_\_ (date)

\_\_\_\_\_  
(Printed or typed name of Applicant’s Authorized Representative)

\_\_\_\_\_  
Authorized Signature of Applicant

\_\_\_\_\_  
Title

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

**ARKANSAS GROUP ACCIDENT INSURANCE ENROLLMENT APPLICATION**

**Catlin Insurance Company, Inc.**

For information and customer service call: {Catlin Insurance Company, Inc.} Toll Free # {1-877-

CATLIN-US (1-877-228-5468)}

All info must be completed by the applicant.

He/she must sign and date this form.

This form cannot be considered unless received within 10 days of the date it is dated.

Can use to insert Catlin logo

**[ADMINISTRATOR RETURN ADDRESS]**

**Important:** Please enter all dates in mm/dd/yyyy format.

**POLICYHOLDER USE (MANDATORY DATA NEEDED):**

In order to process this application, the Policyholder must complete this information.

**POLICYHOLDER**

<b>CLASS</b>	<b>LOCATION/PAYCODE #</b>	<b>DATE OF BIRTH</b>	<b>ANNUAL SALARY</b>
_____	_____	_____	_____

Please print (preferably in black ink).

**REASON FOR REQUEST:**     **NEW HIRE**                       **INITIAL ENROLLMENT**  
 **ONGOING ENROLLMENT**             **LATE ENTRANT**

<b>[EMPLOYEE] [MEMBER] SECTION</b>			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. (Check One)			
Name _____	Social Security # _____	Birthdate _____	
Address _____		City _____	State _____ Zip _____
Work Phone _____	Home Phone _____	ID Number _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

<b>COMPLETE IF ELECTING SPOUSE/[DOMESTIC PARTNER COVERAGE]</b>	
I am currently married and my date of marriage is: _____ [- <input type="checkbox"/> I currently have an eligible Domestic Partner.*] or-	
<b>Spouse/[Domestic Partner] Information</b>	Name (First) _____ (Last) _____ Social Security # _____
	Birthdate _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
*[In order to be eligible for Domestic Partner coverage, you must have a Domestic Partner Affidavit or its equivalent on file with the Policyholder, and accepted by the Insurance Company. If you do not currently have one on file with the Policyholder, one will be made available through the Policyholder.]	

<b>BENEFIT SECTION [OPTION 1]</b>	
<b>Applicant</b>	<b>Amount*</b>
[Employee] [Member]	

<b>BENEFIT SECTION [OPTION 2]</b>				
<b>Applicant</b>	<b>Accept</b>	<b>Reject</b>	<b>Requested Amount</b>	<b>Maximum Coverage*</b>
[Employee] [Member]			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
Spouse			Number of [\$1000 - \$10,000] Units:	\$
Dependent Children			Number of [\$1000 - \$10,000] Units:	\$

<b>BENEFIT SECTION [OPTION 3]</b>				
<b>Applicant</b>	<b>Accept</b>	<b>Reject</b>	<b>Requested Amount</b>	<b>Maximum Coverage*</b>
[Employee] [Member] Only*			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
Family Plan:*				
[Employee] [Member] Spouse (no dependent children)			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
			[0 - 100%] of [Employee's] [Member's] Benefit	\$

Spouse (w dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (no Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (w Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$

**BENEFIT SECTION [OPTION 4]**

<i>Applicant</i>	<i>Accept</i>	<i>Reject</i>	<i>Requested Amount</i>	<i>Maximum Coverage*</i>
[Employee] [Member]			Number of [\$1000 - \$10,000] Units:	\$
Spouse			Number of [\$1000 - \$10,000] Units:	\$
Dependent Children			Number of [\$1000 - \$10,000] Units:	\$

**BENEFIT SECTION [OPTION 5]**

<i>Applicant</i>	<i>Accept</i>	<i>Reject</i>	<i>Requested Amount</i>	<i>Maximum Coverage*</i>
[Employee] [Member] Only*			Number of [\$1000 - \$10,000] Units:	\$
Family Plan:*				
[Employee] [Member] Spouse (no dependent children)			Number of [\$1000 - \$10,000] Units:	\$
Spouse (w dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (no Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (w Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$

\* All insurance is subject to age-based reduction schedule:

† Medical underwriting of applicants is required for certain amounts of insurance.

**BENEFICIARY**

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and dependent child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

<i>Insured</i>	<i>Beneficiary(ies)</i>	<i>Percentage</i>	<i>Social Security #</i>	<i>Date of Birth</i>	<i>Relationship</i>
[Employee] [Member] (Policyholder) Paid Coverage)					
[Employee] [Member] (Employee/Member) Paid Coverage)					

**◆◆◆ACCEPTANCE/DECLINATION◆◆◆**

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.

 Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Sign Here**

**Important: You must sign and date the Agreements section.**

Applicant's  
Name

Social Security  
#

◆◆◆ AGREEMENTS ◆◆◆

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am an active Employee or an active Member on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.



Sign Here

\_\_\_\_\_  
*[Employee's] [Member's] Signature*

\_\_\_\_\_  
*Month/Day/Year*

Applicant's  
Name

Social Security  
#

◆◆◆ AUTHORIZATION TO RELEASE INFORMATION ◆◆◆

I hereby authorize any: physician; medical practitioner; Hospital; clinic or other medical related facility; insurance company; insurance support organization; business partner, pharmacy, government agency; group policyholder; employer; benefit plan administrator; the Medical Information Bureau; the Department of Motor Vehicle Registration; and paramedical facility, to provide Catlin Insurance Company, Inc. or to any: agent; attorney; consumer reporting agency; or independent administrator; including: medical record retrieval services; or pharmaceutical services; acting on Catlin Insurance Company or its reinsurers' behalf, information concerning: advice; care; or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to: medical history; medical conditions; treatment; hospitalizations or confinements; ailments; and/or drug; alcohol; or tobacco usage of the Applicant(s). It is understood that Catlin Insurance Company, Inc. underwriters; claim examiners; reinsurers; attorneys; or the medical director may disclose such health information to the aforementioned parties for purposes of: underwriting; compliance; record clarification or explanation; or in response to: litigation; summons; or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- 1) such information will be used by Catlin Insurance Company, Inc. for underwriting and insurability determinations;
- 2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
- 3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- 4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Underwriting Department of Catlin Insurance Company, Inc. [1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056].  
*I may inspect or copy any information used or disclosed under this authorization, if signed.*

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



Sign Here

\_\_\_\_\_  
*Applicant's Signature*

\_\_\_\_\_  
*Month/Day/Year*

Applicant's  
Name

Social Security  
#



# NOTICE TO POLICYHOLDERS

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## ARKANSAS NOTICE TO POLICYHOLDERS APPENDIX "A"

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

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

#### DISCLAIMER

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

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

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

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

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

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

# NOTICE TO POLICYHOLDERS

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## COVERAGE

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

## EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

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

# NOTICE TO POLICYHOLDERS

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## LIMITS ON AMOUNT OF COVERAGE

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

SERFF Tracking Number: CATL-126536128 State: Arkansas  
 Filing Company: Catlin Insurance Company, Inc. State Tracking Number: 45308  
 Company Tracking Number: AHAG 051 (AR) 0110  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Arkansas Group Accident  
 Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:**

Neutral

**Overall Percentage of Last Rate Revision:**

0.000%

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Catlin Insurance Company, Inc.	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: CATL-126536128 State: Arkansas  
 Filing Company: Catlin Insurance Company, Inc. State Tracking Number: 45308  
 Company Tracking Number: AHAG 051 (AR) 0110  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Arkansas Group Accident  
 Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	04/12/2010
<b>Comments:</b> Readability Certification is attached.		
<b>Attachment:</b> Arkansas Catlin Group Accident Readability Cert SIGNED.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	04/12/2010
<b>Comments:</b> The Application and Enrollment Forms are attached, and also attached under the Form Schedule tab.		
<b>Attachments:</b> AR CATLIN APPLICATION FINAL CLEAN.pdf AR CATLIN ENR FORM FINAL CLEAN.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	04/12/2010
<b>Comments:</b> Statement of Variability is attached.		
<b>Attachment:</b> Arkansas Catlin Group Accident Statement of Variability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	04/12/2010
<b>Comments:</b> Cover Letter is attached.		
<b>Attachment:</b> Arkansas Catlin Group Accident Cover Letter.pdf		

SERFF Tracking Number: CATL-126536128 State: Arkansas  
Filing Company: Catlin Insurance Company, Inc. State Tracking Number: 45308  
Company Tracking Number: AHAG 051 (AR) 0110  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Arkansas Group Accident  
Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

**Satisfied - Item:** Arkansas Consumer Information Notice  
**Item Status:** Approved-Closed  
**Status Date:** 04/12/2010

**Comments:**  
Arkansas Consumer Information Notice is attached.

**Attachment:**  
CONSUMER INFORMATION NOTICE AR.pdf

**Satisfied - Item:** Reply Letter  
**Item Status:** Approved-Closed  
**Status Date:** 04/12/2010

**Comments:**  
Reply Letter is attached.

**Attachment:**  
Reply to DOI 040910.pdf

## READABILITY CERTIFICATION

To Whom It May Concern:

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

Form #	Title	Combined Flesch Score
AHAG 051 (AR) 0110	Arkansas Group Accident Policy	52.2
AHAG 050 (AR) 0110	Arkansas Group Accident Certificate	
AHAG A01 (AR) 0110	Arkansas Group Accident Insurance Enrollment Application	
AHAG A02 (AR) 0110	Arkansas Application for Group Accident Insurance	

Catlin Insurance Company, Inc.



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Bob Eells  
Director – Regulatory Development

March 12, 2010

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Date

**CATLIN INSURANCE COMPANY, INC.**

Home Statutory Office: 1330 Post Oak Boulevard, Suite 2325 • Houston, Texas 77056  
Administrative Office: 3340 Peachtree Road N.E., Suite 2950 • Atlanta, Georgia 30326  
1-877-CATLIN-US (1-877-228-5468)

(a Stock Insurance Company, hereafter called "the Company")

**Arkansas Application for Group Accident Insurance**

**Part 1— Applicant Information**

Name of Applicant \_\_\_\_\_  
(legal name of entity)

DBA (if applicable) \_\_\_\_\_

Nature of Entity \_\_\_\_\_ SIC Code \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Desired Effective Date: \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Applicant is a:    Corporation    Partnership    Sole Proprietorship    Other \_\_\_\_\_

Are [Employees] [Members] of any affiliate or subsidiary entities to be covered?    Yes    No  
(If yes, please complete the following for each such affiliate/subsidiary. Attach separate sheet if needed.):

Name	Address	Total [Employees] [Members]	Nature of Entity	SIC Code

**Part 2—Participants and Eligibility**

Persons eligible to be covered under the Policy are:

- Full-time Employees (working at least [20 – 40] \_\_\_\_\_ hours per week),
- Other: \_\_\_\_\_

,provided that a written application/enrollment has been made and the required premium paid in accordance with the terms of the Policy.

Class	Description of Classes
1	[All full-time Employees of the Policyholder working at least [20-40] hours per week]
2	[All part-time Employees of the Policyholder working at least [0-40] hours per week]
3	[All active Members of the Policyholder]
4	[All Spouses and Dependent Children of Class 1, 2, or 3]

Any additional classes should be added on the back of this application.

Dependent Children of members of these eligible classes may also be eligible, provided the Dependent Child insurance option in this application is elected by the Applicant, the Policy's requirements for Dependent Child eligibility and enrollment are met, and the correct premium is paid.

Total number of Employees on payroll \_\_\_\_\_ Full-time \_\_\_\_\_ Number eligible for coverage \_\_\_\_\_

WAITING PERIOD:

Initial Group:  None  \_\_\_ Days  \_\_\_ Months  Other \_\_\_\_\_  
 New Enrollees:  None  \_\_\_ Days  \_\_\_ Months  Other \_\_\_\_\_

CONTRIBUTIONS:	Premium Percentage Payable	
	Policyholder	[Employee] [Member]
Class I	[100] %	[0] %
Class II	[0] %	[100] %
Class III	[0] %	[100] %
Class IV	[0] %	[100] %

(If Policyholder pays 100% for any class of participants, all members of that class must be enrolled. Other minimum participation requirements apply.)

**[Part 3—Benefit Options**

- Accidental Death for [Employees] [Members]\*\*†:**  
(Select one option from table below for each eligible class):

Option A—Multiples of annual salary rounded to next highest [\$1,000.00]  
 Option B—Level amount  
 Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Salary Multiplier Maximum [ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Maximum Amount: \$	Option B Level Amount Maximum \$	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I					\$		\$
II					\$		\$
III					\$		\$

- Accidental Death and Dismemberment Insurance for [Employees] [Members]\*\*†:**  
(Select one option from table below for each eligible class):

Option A—Multiples of annual salary rounded to next highest [\$1,000.00]  
 Option B—Level amount  
 Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Salary Multiplier Maximum [ <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Maximum Amount: \$	Option B Level Amount Maximum \$	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I					\$		\$
II					\$		\$
III					\$		\$

**☐ Spouse [& Domestic Partner] Option†:**

(Select one option from table below for each eligible class):

Option A—Percentage of [Employee's] [Member's] Principal Sum

Option B—Level amount

Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Percentage of [Employee's] [Member's] Principal Sum	Option B Level Amount Maximum	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I				%	[\$]	[\$]	[\$]
I				% with Dependent Children	[NA]	[NA]	[NA]
I				% without Dependent Children	[NA]	[NA]	[NA]
II				%	[\$]	[\$]	[\$]
II				% with Dependent Children	[NA]	[NA]	[NA]
II				% without Dependent Children	[NA]	[NA]	[NA]
III				%	[\$]	[\$]	[\$]
III				% with Dependent Children	[NA]	[NA]	[NA]
III				% without Dependent Children	[NA]	[NA]	[NA]

**☐ Dependent Children Option†:**

(Select one option from table below for each eligible class):

Option A—Percentage of [Employee's] [Member's] Principal Sum

Option B—Level amount

Option C – Units of Coverage per [\$1,000.00]

Class	Option			Option A Percentage of [Employee's] [Member's] Principal Sum	Option B Level Amount Maximum	Option C	
	A	B	C			Unit Maximum	Maximum Amount
I				%	[\$]	[\$]	[\$]
I				% with Spouse	[NA]	[NA]	[NA]
I				% without Spouse	[NA]	[NA]	[NA]
II				%	[\$]	[\$]	[\$]
II				% with Spouse	[NA]	[NA]	[NA]
II				% without Spouse	[NA]	[NA]	[NA]
III				%	[\$]	[\$]	[\$]
III				% with Spouse	[NA]	[NA]	[NA]
III				% without Spouse	[NA]	[NA]	[NA]

\* All insurance is subject to age-based reduction schedule:

† Medical underwriting of applicants is required for certain amounts of insurance.

**Additional Accidental Death [and Dismemberment] Coverage:**

Armed Forces Coverage: Yes No

Exposure and Disappearance Coverage: Yes No  
National Guard and Armed Forces Reserve Coverage: Yes No  
Owned Aircraft Coverage: Yes No  
Pilot Coverage: Yes No  
War Risk Coverage: Yes No

**Additional Accident Benefits:**

Additional Occupational Benefit: Yes No  
Bereavement and Trauma Counseling Benefit: Yes No  
Bomb Scare, Bomb Search, or Bomb Explosion Benefit : Yes No  
Bulletproof Vest Benefit: Yes No  
Burial and Cremation Benefit: Yes No  
Child Care Center Benefit: Yes No  
Common Carrier Benefit: Yes No  
Emergency Room Benefit: Yes No  
Escalator Benefit: Yes No  
Felonious Assault and Violent Crime Benefit: Yes No  
HIV Occupational Accident Benefit: Yes No  
Home Alteration and Vehicle Modification Benefit: Yes No  
Hospital Stay Benefit: Yes No  
Private Passenger Benefit: Yes No  
Rehabilitation Benefit: Yes No  
Seatbelt [and Airbag] Benefit: Yes No  
Special Education Benefit: Yes No  
Total Disability Weekly Income Benefit: Yes No  
Waiver of Premium Benefit: Yes No

]

**Part 4—Disclosures; Applicant’s Acceptance of Terms**

Any insurance provided pursuant to this Application shall be subject to all terms and conditions of the Policy issued. It is understood and agreed that only officers of the Company—*not your insurance broker*—are authorized to change, enlarge, vary or waive any requirements of the Policy. No such change, enlargement, variance or waiver shall be valid unless made a part of the Policy by amendment or other written agreement.

If any [Employee] [Member] (or Spouse [and Domestic Partner] or Dependent if coverage elected) is not in Active Service on the date his coverage is scheduled to become effective, his coverage shall not take effect until he returns to Active Service.

***Applicant understands that no insurance shall take effect until all underwriting requirements of the Company have been met. It is further understood that any insurance provided shall take effect on the effective date approved by the Company, and that Applicant should not cancel any predecessor policy or plan until notified by the Company that this Application has been approved.***

Dated at \_\_\_\_\_ (city, state) on \_\_\_\_\_ (date)

\_\_\_\_\_  
(Printed or typed name of Applicant’s Authorized Representative)

\_\_\_\_\_  
Authorized Signature of Applicant

\_\_\_\_\_  
Title

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

**ARKANSAS GROUP ACCIDENT INSURANCE ENROLLMENT APPLICATION**

**Catlin Insurance Company, Inc.**

For information and customer service call: {Catlin Insurance Company, Inc.} Toll Free # {1-877-

CATLIN-US (1-877-228-5468)}

All info must be completed by the applicant.

He/she must sign and date this form.

This form cannot be considered unless received within 10 days of the date it is dated.

Can use to insert Catlin logo

**[ADMINISTRATOR RETURN ADDRESS]**

**Important:** Please enter all dates in mm/dd/yyyy format.

**POLICYHOLDER USE (MANDATORY DATA NEEDED):**

In order to process this application, the Policyholder must complete this information.

**POLICYHOLDER**

<b>CLASS</b>	<b>LOCATION/PAYCODE #</b>	<b>DATE OF BIRTH</b>	<b>ANNUAL SALARY</b>
_____	_____	_____	_____

Please print (preferably in black ink).

**REASON FOR REQUEST:**     **NEW HIRE**                       **INITIAL ENROLLMENT**  
 **ONGOING ENROLLMENT**             **LATE ENTRANT**

<b>[EMPLOYEE] [MEMBER] SECTION</b>			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. (Check One)			
Name _____	Social Security # _____	Birthdate _____	
Address _____		City _____	State _____ Zip _____
Work Phone _____	Home Phone _____	ID Number _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

<b>COMPLETE IF ELECTING SPOUSE/[DOMESTIC PARTNER COVERAGE]</b>	
I am currently married and my date of marriage is: _____ [- <input type="checkbox"/> I currently have an eligible Domestic Partner.*] or-	
<b>Spouse/[Domestic Partner] Information</b>	Name (First) _____ (Last) _____ Social Security # _____
	Birthdate _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
*[In order to be eligible for Domestic Partner coverage, you must have a Domestic Partner Affidavit or its equivalent on file with the Policyholder, and accepted by the Insurance Company. If you do not currently have one on file with the Policyholder, one will be made available through the Policyholder.]	

<b>BENEFIT SECTION [OPTION 1]</b>	
<b>Applicant</b>	<b>Amount*</b>
[Employee] [Member]	

<b>BENEFIT SECTION [OPTION 2]</b>				
Applicant	Accept	Reject	Requested Amount	Maximum Coverage*
[Employee] [Member]			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
Spouse			Number of [\$1000 - \$10,000] Units:	\$
Dependent Children			Number of [\$1000 - \$10,000] Units:	\$

<b>BENEFIT SECTION [OPTION 3]</b>				
Applicant	Accept	Reject	Requested Amount	Maximum Coverage*
[Employee] [Member] Only*			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
Family Plan:*				
[Employee] [Member] Spouse (no dependent children)			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
			[0 – 100%] of [Employee's] [Member's] Benefit	\$

Spouse (w dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (no Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (w Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$

**BENEFIT SECTION [OPTION 4]**

<i>Applicant</i>	<i>Accept</i>	<i>Reject</i>	<i>Requested Amount</i>	<i>Maximum Coverage*</i>
[Employee] [Member]			Number of [\$1000 - \$10,000] Units:	\$
Spouse			Number of [\$1000 - \$10,000] Units:	\$
Dependent Children			Number of [\$1000 - \$10,000] Units:	\$

**BENEFIT SECTION [OPTION 5]**

<i>Applicant</i>	<i>Accept</i>	<i>Reject</i>	<i>Requested Amount</i>	<i>Maximum Coverage*</i>
[Employee] [Member] Only*			Number of [\$1000 - \$10,000] Units:	\$
Family Plan:*				
[Employee] [Member]			Number of [\$1000 - \$10,000] Units:	\$
Spouse (no dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Spouse (w dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (no Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (w Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$

\* All insurance is subject to age-based reduction schedule:

† Medical underwriting of applicants is required for certain amounts of insurance.

**BENEFICIARY**

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and dependent child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

<i>Insured</i>	<i>Beneficiary(ies)</i>	<i>Percentage</i>	<i>Social Security #</i>	<i>Date of Birth</i>	<i>Relationship</i>
[Employee] [Member] (Policyholder) Paid Coverage)					
[Employee] [Member] ([Employee] [Member]) Paid Coverage)					

**◆◆◆ACCEPTANCE/DECLINATION◆◆◆**

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.



Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Sign Here**

**Important: You must sign and date the Agreements section.**

**Applicant's  
Name**

**Social Security  
#**

**◆◆◆ AGREEMENTS ◆◆◆**

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am an active Employee or an active Member on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.



**Sign Here**

***[Employee's] [Member's] Signature***

***Month/Day/Year***

**Applicant's  
Name**

**Social Security  
#**

**◆◆◆ AUTHORIZATION TO RELEASE INFORMATION ◆◆◆**

I hereby authorize any: physician; medical practitioner; Hospital; clinic or other medical related facility; insurance company; insurance support organization; business partner, pharmacy, government agency; group policyholder; employer; benefit plan administrator; the Medical Information Bureau; the Department of Motor Vehicle Registration; and paramedical facility, to provide Catlin Insurance Company, Inc. or to any: agent; attorney; consumer reporting agency; or independent administrator; including: medical record retrieval services; or pharmaceutical services; acting on Catlin Insurance Company or its reinsurers' behalf, information concerning: advice; care; or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to: medical history; medical conditions; treatment; hospitalizations or confinements; ailments; and/or drug; alcohol; or tobacco usage of the Applicant(s). It is understood that Catlin Insurance Company, Inc. underwriters; claim examiners; reinsurers; attorneys; or the medical director may disclose such health information to the aforementioned parties for purposes of: underwriting; compliance; record clarification or explanation; or in response to: litigation; summons; or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- 1) such information will be used by Catlin Insurance Company, Inc. for underwriting and insurability determinations;
- 2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
- 3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- 4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Underwriting Department of Catlin Insurance Company, Inc. [1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056]. *I may inspect or copy any information used or disclosed under this authorization, if signed.*



**Sign Here**

***Applicant's Signature***

***Month/Day/Year***

**Applicant's  
Name**

**Social Security  
#**

**Catlin Insurance Company, Inc.**  
**STATEMENT OF VARIABILITY**  
**for**  
**Arkansas Group Accident Policy AHAG 051 (AR) 0110**

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

<b>Provision/Title</b>	<b>Variable #</b>	<b>Description of Variable</b>
Face Page	1	Company address may change
	2	POLICYHOLDER – John Doe information
	3	POLICY NUMBER - John Doe information
	4	POLICY EFFECTIVE DATE - John Doe information
	5	POLICY ANNIVERSARY - John Doe information
	6	30 Day Right To Examine Certificate – number of days will be between 30 and 90 days
	7	30 DAY RIGHT TO EXAMINE CERTIFICATE – {a Covered Person} may change to Member, Subscriber, Participant, etc.
TABLE OF CONTENTS	1	Page Numbers may change
	2	Description of Benefits – varies by case
	3	Additional Accidental Death and Dismemberment Coverages – varies by case
	4	Additional Accident Benefits – varies by case
SCHEDULE OF AFFILATES	1	Varies by case; some groups will have affiliates that are part of the overall plan , but have a different name or address of the policyholder
	2	Affiliate Name – varies by case, there could be multiple named affiliates
	3	Location – varies by case, there could be multiple affiliates in many different locations.
	4	Effective Date – varies by case and individual affiliates could have different effective dates during policy period.
SCHEDULE OF BENEFITS	1	Subscriber – i.e., Subscriber, Company, Employer name, Discretionary Group, etc.
	2	Effective Date – varies by case, it can be any day of the year and is mostly determined by the Policyholder.
	3	Minimum Participation Requirement – varies by case and based on funding requirements of the policyholder, Percent ranges from 0% to 100%
	4	Covered Classes – varies by case, no limit on number of classes.
	5	Eligibility Waiting Period – varies by case; 0 days to 365 days maximum
	6	Time Period for Loss – varies by case; 90 days to 365 days maximum
ACCIDENTAL DEATH BENEFIT	1	Principal Sum - varies by case for Employee, Member, Participant, Spouse, Dependent Child(ren); benefit range from \$1,000 to \$10,000,000 per person maximum.
	2	Age Reductions - varies by case; age tiers vary by case,

		range from age 65 to 85, Tiers can range from 1 to 6 tiers
	3	Age Reduction – reduction percentage: varies by case, percentage is applied to benefit amount before reduction. Ranges from 0% to 85%.
	4	Aggregate Limit of Liability, inclusion varies by case, The Company’s underwriting judgment is a determinant of an aggregate limit. Actual Aggregate Limit of liability ranges from \$500,000 to \$50,000,000 maximum. This provision may include an adjustment to premium rate.
<b>ACCIDENTAL DEATH AND DISMEMBRMENT BENEFIT</b>		
	1	Principal Sum - varies by case for Employee, Member, Participant, Spouse, Dependent Child(ren); benefit range from \$1,000 to \$10,000,000 per person maximum. Principal Sum is negotiated between Policyholder and Company. And based on underwriting of judgment of the Company.
	2	SCHEDULE OF COVERED LOSSES, table of covered losses varies by case, range from 0% to 100%. Items in the Schedule of Covered losses can vary by case based on underwriting judgment of the Company and negotiations with the Policyholder. This provision may include an adjustment to premium rate.
	3	Age Reductions - varies by case; age tiers vary by case, range from age 65 to 85. This provision may include an adjustment to premium rate.
	4	Age Reduction - Percentage of Benefit Amount - varies by case; range from 0% to 85%.
	5	Aggregate Limit of Liability - inclusion varies by case; range from \$500,000 to \$50,000,000 maximum. This provision may include an adjustment to premium rate. The Company’s underwriting judgment is a determinant of an aggregate limit,.
<b>ADDITIONAL ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGES</b>		
	1	Varies by case. It is usually the Company’s underwriting discretion and negotiation with the Policyholder that determines inclusion of as to whether to extend ADDITIONAL ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGES
	2	ARMED FORCES COVERAGE - inclusion varies by case and determined by underwriting judgment and negotiation with Policyholder. There would need to be potential Insureds that are active or retired Armed Forces members to include this condition of coverage. This provision may include an adjustment to premium rate.
	3	EXPOSURE AND DISAPPEARANCE COVERAGE – varies by case. Inclusion based on underwriting judgment and negotiation with policyholder.
	4	NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE - inclusion varies by case; and determined by underwriting judgment and negotiation with Policyholder. There would need to be potential Insureds that are active or retired Armed Forces or National Guard members to include this condition of coverage. This provision may include an adjustment to premium rate
	5	OWNED AIRCRAFT COVERAGE - inclusion varies by case; and determined by underwriting judgment and

		negotiation with Policyholder. Information on owned aircraft is a requirement to include. This provision may include an adjustment to premium rate.
	6	PILOT COVERAGE - inclusion varies by case; and determined by underwriting judgment and negotiation with Policyholder. Information on pilots to be covered is a requirement to include. This provision may include an adjustment to premium rate.
	7	WAR RISK COVERAGE - inclusion varies by case; and determined by underwriting judgment and negotiation with Policyholder. This provision may include an adjustment to premium rate.
<b>ADDITIONAL ACCIDENT BENEFITS</b>		
	1	Inclusion varies by case. Additional Benefits are included based on our Underwriting judgment and negotiations with the Policyholder. These provisions will include an adjustment to premium rate in most cases.
	2	ADDITIONAL OCCUPATIONAL BENEFIT – inclusion varies by case; percent of Principal Sum applicable to Covered Loss ranges from 5% to 100% maximum.
	3	BEREAVEMENT AND TRAUMA COUNSELING BENEFIT - inclusion varies by case; Benefit Amount – range of \$25 to \$500 per session Maximum Number of Sessions – range of 3 to 25 sessions Maximum Benefit Per Covered Accident - \$75 to \$12,500
	4	BOMB SCARE, BOMB SEARCH, OR BOMB SEARCH, OR BOMB EXPLOSION BENEFIT – inclusion varies by case; percent of Principal Sum applicable to Covered Loss ranges from 5% to 100% maximum
	5	BULLETPROOF VEST BENEFIT - inclusion varies by case; percent of Principal Sum applicable to Covered Loss ranges from 5% to 100% maximum
	6	BURIAL AND CREMATION BENEFIT - inclusion varies by case; benefit ranges from \$1,000 to \$10,000 maximum.
	7	BUSINESS TRAVEL BENEFIT - inclusion varies by case; percent of Principal Sum applicable to Covered Loss ranges from 5% to 100% maximum
	8	CHILD CARE CENTER BENEFIT - inclusion varies by case; Benefit Amount – range of \$500 to \$10,000 per year Maximum Benefit Period – to Age range from age 11 to age 18
	9	COMMON CARRIER BENEFIT – inclusion varies by case; percent of Principal Sum applicable to Covered Loss ranges from 5% to 100% maximum
	10	COMMON CARRIER – stand alone coverage – inclusion varies by case. Covered Loss – varies by case Benefit – varies by case, benefit ranges from \$1,000 to \$5,000,000
	11	EMERGENCY ROOM BENEFIT – inclusion varies by case Benefit Amount – varies by class, benefit ranges from \$100 to \$5,000.

		Maximum Payable Visits per Calendar Year – varies by case, visits range from 1 to 365 per year Maximum Benefit Per Covered Accident – varies by case, benefit ranges from \$1,000 to \$50,000.
	12	ESCALATOR BENEFIT – inclusion varies by case Periodic Increase – varies by case; percent increase to Principal Sum ranges from 1% to 20% Frequency of Increases – varies by case; monthly, semi-annually, annually Maximum Total Increase – varies by case; range from 1% to 100%
	13	FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT – inclusion varies by case AD&D Benefit – varies by case, percent of Principal Sum applicable to Covered Loss ranges from 5% to 100% maximum Hospital Stay Benefit – varies by class, per day benefit ranges from \$100 to \$2,000. Maximum Benefit Period Per Covered Accident – varies by case; ranges from 30 days to 730 days
	14	HIV OCCUPATIONAL ACCIDENT BENEFIT – inclusion varies by case; percent of Principal Sum ranges from 5% to 100% maximum, subject o a maximum benefit of \$1,000 to \$500,000 maximum.
	15	HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT – inclusion varies by case stand alone coverage – inclusion varies by case. Covered Loss – varies by case Benefit – varies by case, benefit ranges from \$1,000 to \$5,000,000
	16	HOSPITAL STAY BENEFIT – varies by case; Benefit Amount – varies by case; range of \$50 to \$5,000 per day Maximum Benefit Period – varies by case; Maximum Benefit Period Per Covered Accident – varies by case; ranges from 30 days to 730 days Benefit Waiting Period – varies by case; ranges is 0 days to 30 days
	17	PRIVATE PASSENGER BENEFIT – inclusion varies by case Stand alone coverage – inclusion varies by case. Covered Loss – varies by case Benefit – varies by case, benefit ranges from \$1,000 to \$5,000,000
	18	REHABILITATION BENEFIT – inclusion varies by case; percent of Principal Sum ranges from 5% to 100% maximum, subject o a maximum benefit of \$1,000 to \$500,000 maximum.
	19	SEATBELT [AND AIRBAG] BENEFIT – inclusion varies by case; AIRBAG – inclusion varies by case Seatbelt Benefit - percent of Principal Sum ranges from 5% to 100% maximum, subject o a maximum benefit of \$1,000 to \$500,000 maximum Airbag Benefit - percent of Principal Sum ranges from 5% to 100% maximum, subject o a maximum benefit of \$1,000 to

		\$500,000 maximum Default Benefit – varies by class; benefit range \$1,000 to \$10,000
	20	SPECIAL EDUCATION BENEFIT – inclusion varies by case Surviving Dependent Child Benefit – varies by case; percent of Principal Sum ranges from 5% to 100% maximum, subject o a maximum benefit of \$1,000 to \$50,000 maximum Surviving Spouse Benefit – inclusion varies by case; percent of Principal Sum ranges from 5% to 100% maximum, subject o a maximum benefit of \$1,000 to \$50,000 maximum Maximum Number of Annual Payments – varies by case; For Each Surviving Dependent Child – varies by case; range of 1 to 10 payments For Surviving Spouse – varies by case; range of 1 to 10 payments Default Benefit – inclusion varies by case; benefit range \$1,000 to \$10,000
	21	TOTAL DISABILITY WEEKLY INCOME BENEFIT – inclusion varies by case Weekly Benefit Period – varies by case; range is \$100 to \$5,000 Benefit Waiting Period – varies by case; ranges is 0 days to 30 days Maximum Benefit Period per Covered Accident – varies by case; range 1 week to 52 week maximum
	22	WAIVER OF PREMIUM BENEFIT – inclusion varies by case Benefit Waiting Period – varies by case; range 1 month to 12 months Benefit Period – varies by case Age when Total Disability Begins - less than age 60 – range to 60 <sup>th</sup> birthday to 75 <sup>th</sup> birthday - 60 and later – range 60 months to 180 months
INITIAL PREMIUM RATES	1	Premium modes and rates varies by case;
	2	Premium Rate – varies by case based on plan of benefits Rates per Employee, Spouse, Child(ren) and Family Plan
	3	Mode of Premium Payment – varies by case. Values are Monthly, Quarterly, Semi-annual, Annual & Nine months
	4	Contributions – varies by case. Policyholder: 0% to 100%; Covered Person and/or Employee – 0% to \$100; Split-funded, Employer & Employee each fund a piece from 0% to 100%.
	5	Premium Due Dates – varies by case. Can be from January 1 to December 31 of any given year.



**WESTMONT  
ASSOCIATES, INC.**

March 30, 2010

via SERFF

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

**Re: Catlin Insurance Company, Inc.**  
**FEIN#: 204929941**  
**NAIC#: 4574 19518**

**Arkansas Group Accident Insurance Policy – Form #AHAG 051(AR) 0110**  
**Arkansas Group Accident Insurance Certificate – Form #AHAG 050(AR) 0110**  
**Arkansas Group Accident Insurance Enrollment Form – Form #AHAG A01(AR) 0110**  
**Arkansas Group Application for Group Accident Insurance – Form #AHAG A02(AR) 0110**

Honorable Commissioner Benafield Bowman:

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

This is a new group accident product submission. The forms are new and are not intended to replace any other forms currently in use.

Arkansas Group Accident Policy Form #AHAG 051(AR) 0110, provides accident benefits on a Group basis to groups recognized as eligible groups under the laws of your state, including but not limited to employer groups, unions, associations and customers of financial institutions. Optional provisions are chosen by the policyholder at the time of application. Certain wording and benefit amounts reflected in the subject forms is enclosed within brackets ([ ]) and may vary according to a specific plan design. The variable material shown in the policy reflects the benefit levels selected and insured specific information. The variable language or amounts on final printed forms will be no more restrictive than that which is reflected in the enclosed forms and within legal requirements. Please see the enclosed Statement of Variability for Catlin's explanation of how these forms may vary to accommodate different product offerings.

The Arkansas Certificate of Insurance, Form # AHAG 050(AR) 0110, will be issued to describe the plan benefits when required by law or as requested by the policyholder. When issued, this form will mirror the plan specification as set forth in the policy.

The Group Accident Insurance Enrollment Application, Form #AHAG A01(AR) 0110, will be used for any eligible groups where an individual enrollment is mandated.

The enclosed Application for Group Accident Insurance, Form #AHAG A02(AR) 0110, will detail the benefits applicable to the organization and will be signed by the policyholder.

The enclosed Group Accident Insurance product will be marketed by licensed agents, brokers, and third party administrators to eligible groups.

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

- Certification of Compliance
- Unfair Sex Discrimination Certificate of Compliance
- Life & Health Guaranty Association Act Notice to Policyholders
- Flesch Certification
- Forms
- Statement of Variables

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

Respectfully,

***Darcy Lebau***

Darcy Lebau

**CONSUMER INFORMATION NOTICE**

You may contact Catlin Insurance Company at:

Catlin Insurance Company  
3340 Peachtree Road N.E., Suite 295  
Atlanta, GA 30326  
1-877-CATLIN-US

You may contact the Arkansas Insurance Department at:

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

(If applicable)

You may contact your Agent at:

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March 30, 2010

via SERFF

Ms. Rosalind Minor  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
*Attention: Life & Health Division*

**Re: Catlin Insurance Company, Inc.**  
**FEIN#: 204929941**  
**NAIC#: 4574 19518**

**Arkansas Group Accident Insurance Policy – Form #AHAG 051(AR) 0110**  
**Arkansas Group Accident Insurance Certificate – Form #AHAG 050(AR) 0110**  
**Arkansas Group Accident Insurance Enrollment Form – Form #AHAG A01(AR) 0110**  
**Arkansas Group Application for Group Accident Insurance – Form #AHAG A02(AR) 0110**

Ms. Minor:

By Letter dated 4/1/2010, the Arkansas DOI objected to the above referenced filing. A copy of the Objection Letter is attached. This Memorandum will identify the revisions Catlin Insurance Company, Inc. made in response to your objections.

*Objection 1*

AHAG 051 (AR) 0110, Policy/Contract/Fraternal Certificate, Arkansas Catlin Group Accident Policy (Form)

AHAG 050 (AR) 0110, Certificate, Arkansas Catlin Group Accident Certificate (Form)  
*Comment: With respect to exclusions for Terrorism or Terrorism Acts, this is to advise that our Department is not approving Terrorism or Terrorism type exclusions. It is requested that these exclusions be deleted.*

**The Company has made the following form revisions:**

**Page 20:**

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**COMMON EXCLUSIONS**

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

- [1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane];
- [2. commission or attempt to commit a felony or an assault];
- [3. commission of or active participation in: a riot; or insurrection; ~~or Terrorist Act~~];
- [4. {bungee jumping;}{ parachuting;}{ skydiving;}{ parasailing;}{ hang-gliding}}];
- [5. declared or undeclared war or act of war];
- [6. ~~Terrorism [or Terrorist Acts]]];~~

**Page 14:**

<p><del><b>Terrorism or Terrorist Act</b></del></p>	<p><del>[Any hostile or violent act carried out by a group of persons having political or military goals but not operating on behalf of a foreign state and whose purpose is to compel an act or omission by any other person or governmental entity.]</del></p> <p style="text-align: center;"><del>or</del></p> <p><del><b>Domestic Terrorism</b> means the unlawful use, or threatened use, of force or violence, by a group or individual based and operating entirely within the United States or Puerto Rico without foreign direction, committed against persons or property to intimidate or coerce: a government; the civilian population; or any segment thereof; in furtherance of political or social objectives.</del></p> <p><del><b>International Terrorism</b> means violent acts or acts dangerous to human life occurring inside or outside of the United States: that are a violation of the criminal laws of the United States or any state; or that would be a criminal violation if committed within the jurisdiction of the United States or any state. The acts are committed to: intimidate or coerce a civilian population; influence the policy of a government by intimidation or coercion; or affect the conduct of a government by assassination or kidnapping.</del></p> <p><del><b>International Terrorist Group</b> means any group: practicing; or that has significant subgroups that practice; international terrorism that has been designated as a foreign terrorist organization by the United States Department of State.]]</del></p>
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*Objection 2*

☐ AHAG A01 (AR) 0110, Application/Enrollment Form, Arkansas Catlin Group Accident

*Enrollment Form (Form)*

*Comment:*

*This enrollment form must contain a Fraud Statement as outlined under ACA 23-66-503.*

**The Company has made the following form revisions:**

**Page 2:**

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Underwriting Department of Catlin Insurance Company, Inc. [1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056]. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

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



**Sign Here**

\_\_\_\_\_  
***Applicant's Signature***

\_\_\_\_\_  
***Month/Day/Year***

**Applicant's  
Name**

**Social Security  
#**

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

Respectfully,

***Darcy Lebau***

Darcy Lebau

SERFF Tracking Number: CATL-126536128 State: Arkansas  
 Filing Company: Catlin Insurance Company, Inc. State Tracking Number: 45308  
 Company Tracking Number: AHAG 051 (AR) 0110  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Arkansas Group Accident  
 Project Name/Number: Arkansas Group Accident/AHAG 051 (AR) 0110

## 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)
03/11/2010	Form	Arkansas Catlin Group Accident Certificate	04/09/2010	AR CATLIN CERTIFICATE FINAL CLEAN.pdf (Superseded)
03/11/2010	Form	Arkansas Catlin Group Accident Enrollment Form	04/09/2010	AR CATLIN ENR FORM FINAL CLEAN.pdf (Superseded)
03/11/2010	Form	Arkansas Catlin Group Accident Policy	04/09/2010	AR CATLIN POLICY FINAL CLEAN.pdf (Superseded)

**Catlin Insurance Company, Inc.**  
**Statutory Home Office: 1130 Post Oak Boulevard, Suite**  
**2325, Houston, TX 77056**  
**Administrative Office: 3340 Peachtree Road N.E., Suite**  
**2950, Atlanta, GA 30326**  
**A Stock Insurance Company**

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**ARKANSAS GROUP ACCIDENT CERTIFICATE**

THIS CERTIFICATE IS A QUALIFIED GROUP ACCIDENT INSURANCE CONTRACT

Certifies that the Insured is covered under the Policy issued to the Policyholder.

"We", "Our" and "Us" are used to refer to the Catlin Insurance Company, Inc.

This certificate is not the Policy. It is evidence of the [Employee's] [Member's] coverage under the Policy. Coverage is subject to the Policy provisions. The Policy was issued to the Policyholder. The [Employee] [Member] may inspect the Policy at the Policyholder's office during normal business hours.

CAUTION: If the [Employee] [Member] as misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased had such fact been correctly stated.

A copy of the application is attached to this certificate. The best time to clear up any questions is now, before a claim arises. If you have any questions contact Us at this address:

Catlin Insurance Company, Inc.  
{P.O. Box XXXXX}  
{Your city, Your state 0000}

This Certificate describes the terms and conditions of insurance. The laws of the State of Issue govern the Policy.

Signed for Catlin Insurance Company, Inc. at its Home Office, 1330 Post Oak Boulevard, Suite 2325, Houston, Texas 77056.



Secretary

President

Countersigned \_\_\_\_\_

Where Required By Law

### **EFFECTIVE DATE AND TERM**

The Policy starts on the Policy Effective Date. The Covered Person's coverage starts on the Covered Person's Effective Date stated in the Certificate Identification. It stays in-force for the period for which the Covered Person's premium has been paid.

The Covered Person's coverage may be continued in force, as provided in the [Continuation of Insurance];[Continuation for {Layoff; Leave of Absence; Family Medical Leave}];[Continuation for Military Service] clause. If the Policy is not renewed or the Covered Person is no longer eligible for coverage the Covered Person's coverage will cease at the termination date.

## CERTIFICATE IDENTIFICATION

POLICYHOLDER:	{ABC Company, Inc.}
POLICY NUMBER:	{Specimen}
POLICY EFFECTIVE DATE:	{January 1, 2008}
POLICY ANNIVERSARY DATE:	{January 1}
STATE OF ISSUE:	{Any State}
CERTIFICATE NUMBER:	{00000000000}
{COVERED PERSON}:	{John Doe}
{COVERED PERSON'S} DATE OF BIRTH:	{January 1, 2009}
{COVERED PERSON'S} ADDRESS:	{1000 Main Street {Your Town}, {Texas} {10000}
{COVERED PERSON'S} ORIGINAL EFFECTIVE DATE:	
{COVERED PERSON'S} CURRENT COVERAGE EFFECTIVE DATE:	

**(PLEASE NOTE THAT THIS SCHEDULE PAGE REPLACES ANY SCHEDULE PAGE PREVIOUSLY ISSUED TO YOU)**

## SCHEDULE OF BENEFITS

### [Covered Classes

Class 1	All full-time Employees of the Policyholder working at least [20-40] hours per week.
Class 2	All part-time Employees working at least [0-40] hours per week.]
Class 3	All active Members of the Policyholder.
Class 4	All Spouses and Dependent Children of Class 1, 2, or 3. ]

### [Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the [Employee] [Member] must be in a Covered Class to be eligible for coverage. [It will be extended by the number of days the [Employee] [Member] is absent from scheduled work.]

For [Employees] [Members] added [{31 days} or more] before the Policy Effective Date:	{No Waiting Period}
For [Employees] [Members] added [less than {31 days} before, or] after the Policy Effective Date:	{One month}{30 days}{31 days}]

### [Time Period for Loss

[Any Covered Loss must occur within:	{90 - 365 days} of the Covered Accident]]
--------------------------------------	---

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in the Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Covered Person's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

### [ACCIDENTAL DEATH BENEFIT

[[Employee] [Member] Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}
[Spouse Principal Sum:	{\$0 - \$2,000,000 in increments of \$500}
[Dependent Child(ren) Principal Sum:	{\$0 - \$1,000,000}]

### [Age Reductions

A Covered Person's Principal Sum will be reduced by the percentage shown below:

Age	Percentage of Benefit Amount
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member]]]]

**[Aggregate Limit of Liability]**

Each Covered {Aircraft} Accident	{ \$0 - \$5,000,000 for all Covered Persons }
Applies to:	{ Accidental Death and Dismemberment Benefits or Accidental Death Benefits or all coverage and benefits provided by the Policy }

If this aggregate amount does not allow all Covered Persons to be paid the amounts the specified benefits otherwise provide, the amount paid for each Covered Person is the proportion each Loss bears to the Aggregate Limit of Liability. [Covered Aircraft Accident means a Covered Accident involving a scheduled or chartered flight in an Aircraft.]]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS]**

[[Employee] [Member] Principal Sum:	{ \$0 - \$2,000,000 in increments of \$500 }
[Spouse Principal Sum:	{ \$0 - \$2,000,000 in increments of \$500 }
[Dependent Child(ren) Principal Sum:	{ \$0 - \$1,000,000 }

**SCHEDULE OF COVERED LOSSES**

<b>Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{100% of the Principal Sum}}
[Loss of Two or More Hands or Feet	{100% of the Principal Sum}}
[Loss of Sight of Both Eyes	{100% of the Principal Sum}}
[Loss of Speech and Hearing (in both ears)	{100% of the Principal Sum}}
[Loss of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Sight in One Eye	{50% of the Principal Sum}}
[Severance and Reattachment of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Speech	{50% of the Principal Sum}}
[Loss of Hearing (in both ears)	{50% of the Principal Sum}}
[Loss of Thumb and Index Finger of the Same Hand	{25% of the Principal Sum}}
[Loss of all Four Fingers of the Same Hand	{25% of the Principal Sum}}
[Loss of all the Toes of the Same Foot	{20% of the Principal Sum}}

**[Age Reductions]**

A Covered Person's Principal Sum will be reduced by the percentage shown below:

<b>Age</b>	<b>Percentage of Benefit Amount</b>
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member].]]

**[ADDITIONAL ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverages. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits. ]

<b>[ARMED FORCES COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[EXPOSURE AND DISAPPEARANCE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[OWNED AIRCRAFT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[PILOT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[WAR RISK COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]

**[ADDITIONAL ACCIDENT BENEFITS ]**

[Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other {Accidental Death and Dismemberment benefits} payable.]

<b>[ADDITIONAL OCCUPATIONAL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]
<b>[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT</b>	
Benefit Amount	{\$75 per session}
Maximum Number of Sessions	{10 sessions}
Maximum Benefit Per Covered Accident	[\$750]
<b>[BOMB SCARE, BOMB SEARCH, OR BOMB EXPLOSION BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .]

<b>[BULLETPROOF VEST BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]	
<b>[BURIAL AND CREMATION BENEFIT</b>	[\$0 - \$5,000}]	
<b>[BUSINESS TRAVEL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]	
<b>[CHILD CARE CENTER BENEFIT</b>		
Benefit Amount	[\$0 - \$3,000 per year}	
Maximum Benefit Period	{to Age {13} for each surviving Dependent Child}]	
<b>[COMMON CARRIER BENEFIT</b>	{50%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i>	
	<b>[Covered Loss</b>	<b>Benefit</b>
	[Loss of Life	[\$10,000}]
	[Loss of Two or More Hands or Feet	[\$10,000}]
	[Quadriplegia	[\$10,000}]
	[Hemiplegia	[\$5,000}]
	[Uniplegia	[\$5,000}]
	[Coma	[\$5,000}]]]
<b>[EMERGENCY ROOM BENEFIT</b>		
Benefit Amount	[\$200}	
Maximum Payable Visits per Calendar Year	{5}	
Maximum Benefit Per Covered Accident	[\$1,000}]	
<b>[ESCALATOR BENEFIT</b>		
Periodic Increase	{10% of the Principal Sum}	
Frequency of Increases	{Annually}	
Maximum Total Increase	{50% of the Principal Sum}]	
<b>[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT</b>		
Accidental Death and Dismemberment Benefit	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i>	
Hospital Stay Benefit	[\$100 per day}	
Maximum Benefit Period	{730 days per Hospital Stay per Covered Accident}]	
<b>[HIV OCCUPATIONAL ACCIDENT BENEFIT</b>	{25%} of the Principal Sum [subject to a maximum of {\$100,000}]]	
<b>[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT</b>		
Benefit	{10% of the Principal Sum subject to a maximum of \$25,000}]	



**[INITIAL PREMIUM RATES**

Premium Rate:	{Premium amounts will vary based on the plan of benefits: \$123.45} per {covered [Employee] [Member], Covered Person, and covered Spouse, per Dependent Child, per month}
Mode of Premium Payment:	{Monthly; Quarterly; Semi-Annually; Annually}
Contributions:	The cost of coverage is paid by the {Policyholder; Policyholder and Covered Person;
Premium Due Dates:	The Policy Effective Date and the first day of each succeeding {interval}[month].

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of the Policy. [Each Covered Person's premiums are based on his plan of benefits and class and may increase on the next premium due date.

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## GENERAL DEFINITIONS

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Please note that certain words used in the Policy have specific meanings. The words defined below and capitalized within the text of the Policy have the meanings set forth below.

<b>[Active Service]</b>	<p>[An [Employee] [Member] will be considered in Active Service with the Policyholder on any day that is either of the following:</p> <ol style="list-style-type: none"><li>1. [one of the Policyholder's scheduled work days on which the [Employee] [Member] is performing his regular duties on a full-time basis, either at one of the Policyholder's usual places of business or at some other location to which the Policyholder's business requires the [Employee] [Member] to travel;]</li><li>2. [a scheduled holiday; vacation day; or period of approved paid leave of absence; other than sick leave, only if the [Employee] [Member] was in Active Service on the Preceding scheduled workday;]</li><li>3. [a day on which the Member meets all the conditions of membership of the Policyholder.]]</li></ol> <p>[An eligible Dependent Child or eligible Spouse of the [Employee] [Member] is considered in Active Service if he is none of the following:</p> <ol style="list-style-type: none"><li>1. an Inpatient in a Hospital; or receiving Outpatient care for chemotherapy or radiation therapy;</li><li>2. Confined at home under the care of Physician for Sickness or Injury;</li><li>3. Totally Disabled.]]</li></ol>
<b>[Age]</b>	<p>A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under the Policy. {Thereafter, it is his Age attained on: [the last Policy anniversary;] or [his last birthday.]}]</p>
<b>[Aircraft]</b>	<p>A vehicle which:</p> <ol style="list-style-type: none"><li>1. has a valid certificate of airworthiness; and</li><li>2. is being flown by a pilot with a valid license to operate the Aircraft.]]</li></ol>
<b>[Certificate]</b>	<p>The Certificate is not the Policy and is evidence of the Employee/Member's coverage under the Policy. Coverage is subject to the Policy provisions.]]</p>
<b>Complications of Pregnancy</b>	<p>Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; but does not include: false labor; pre-term or premature labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning Sickness; hyperemesis gravidarum; pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Also included is: a non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.</p>
<b>[Core Plan]</b>	<p>The noncontributory plan of benefits provided under the Policy.]]</p>

**Covered Accident**

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under the Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. [occurs while the Covered Person is {any of the following may be included: attending, participating in, or traveling to and from any event sponsored by the Policyholder};
4. is not otherwise excluded under the terms of the Policy.

**[Covered Injury**

Any bodily harm that results directly and independently of all other causes from a Covered Accident.]

**[Covered Loss**

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the Schedule of Covered Losses;
3. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits*.]

**Covered Person**

An eligible person in a covered class, as shown in the Schedule of Benefits: for whom an enrollment form has been accepted by Us; and required premium has been paid when due; and for whom coverage under the Policy remains in force. [The term Covered Person shall include, where the Policy provides coverage, an eligible Spouse and eligible Dependent Children.]

**[Dependent Child(ren)**

An [Employee's] [Member's] unmarried child who meets the following requirements:

1. A child from live birth to {19} years old;
2. A child who is {19} or more years old but less than {23} years old, enrolled in a school [as a full-time student] and primarily supported by the [Employee] [Member];
3. A child who is {19} or more years old, chiefly dependent on the [Employee] [Member] for support and maintenance and incapable of - sustaining employment by reason of mental retardation or physical disability, who became so incapable prior to his 19<sup>th</sup> birthday. Notice of the child's condition and dependence must be submitted to Us . If the incapacity or dependency is later removed or terminated, the [Employee] [Member] must notify Us of the change.

A child, for purposes of this provision, includes an [Employee's] [Member's]:

1. natural child;
2. child under the charge, care, and control of the [Employee] [Member] whom the [Employee] [Member] has filed a petition to adopt, until the dismissal or denial of the petition for adoption;
3. stepchild [who resides with the [Employee] [Member]];
4. [child for whom the [Employee] [Member] is legal guardian.]

[If an [Employee] [Member] who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with the [Employee] [Member] for at least [six consecutive months] and intend to reside with the [Employee] [Member] for an indefinite period of time.]]

**[Domestic Partners**

A person of the same or opposite sex who:

1. shares the covered [Employee's] [Member's] permanent residence;
2. has resided with the covered [Employee] [Member] continuously for at least {six months to two years} and is expected to reside with the covered [Employee] [Member] indefinitely;
- [3. Is financially interdependent with the covered [Employee] [Member] in each of the following ways:
  - [a. by holding one or more credit or bank accounts, including a checking account, as joint owners;]
  - [b. by owning or leasing their permanent residence as joint tenants;]
  - [c. by naming, or being named by, the covered [Employee] [Member] as a beneficiary of life insurance or under a will;]
  - [d. by each agreeing in writing to assume financial responsibility for the welfare of the other;]]
- [4. has signed a Domestic Partner declaration with the covered [Employee] [Member], if the covered [Employee] [Member] resides in a jurisdiction which provides for a Domestic Partner declaration;]
- [5. has not signed a Domestic Partner declaration with any other person within the last {12- 24 months;}]
6. is no less than {any Age from 18 to 23} years not more than { 60 - 70} years of age;
- [7. is not legally permitted to marry the covered [Employee] [Member];]
8. is not legally married to any other person;
9. is not a blood relative any closer than would prohibit legal marriage.

[In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.]

A covered [Employee] [Member] may insure a Domestic Partner if all of the following conditions are met:

1. the covered [Employee] [Member] has not been married to any person within the past {12 - 24} months;
2. the Domestic Partner is the only person meeting the Policy's definition of "Domestic Partner" with respect to the covered [Employee] [Member];
- [3. The covered [Employee] [Member] and the Domestic Partner furnish a notarized affidavit/signed statement reflecting these requirements, and an agreement to notify Us if the requirements cease to be met, on a form acceptable to Us.]]

**[Effective Date**

The date on which insurance under the Policy begins as shown in the Schedule of Benefits.]

**[Emergency Room Treatment**

Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in deterioration to the point of placing a Covered Person's life in jeopardy or cause serious impairment to bodily functions.]

**Employee**

For eligibility purposes, an Employee of the Policyholder who is in one of the covered classes. [The term does not include Employees who work less than {20 - 30 hours per week} for the Policyholder.]]

**[Employer**

The Policyholder and any affiliates, subsidiaries or divisions shown in the *Schedule of Covered Affiliates* and which are covered under the Policy on

the date of issue or subsequently agreed to by Us.]

**[He, His, Him**

Refers to any individual, male or female.]

**[Hospital**

An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

[Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.]

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.]]

**[Hospital Stay**

A confinement in a Hospital, ordered by a Physician, over a period of time when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least {90 days - 180 days}.

**[Inpatient**

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.]

**[Insured**

A person: (1) who is a member of an eligible class of person as described in the Schedule of Benefits; (2) for whom premium has been paid; and (3) while covered under this Policy.]

**[Member**

For eligibility purposes, a Member is any one of the following:

- [1. an Employee of the Policyholder, [not including a temporary or seasonal Employee];]
- [2. an Employee of a Member in good standing of a Policyholder [, not including a temporary or seasonal employee];]
- [3. a person who meets all of the conditions of membership of a Policyholder];

[and who is [Optional, a United States citizen or has a permanent alien registration card and who is] in one of the Covered Classes.]]

<b>[Nurse</b>	A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not: <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household; or</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>
<b>[Outpatient</b>	A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.]
<b>[Permanent Total Disability</b>	An [Employee] [Member] [Spouse] who is Totally Disabled and is expected to remain Totally Disabled, as certified by a Physician, for the rest of his life.
<b>[Physical Therapist</b>	Any practitioner of physical therapy who is duly licensed in the state where he is practicing and who is practicing within the scope and limitations of that license.]
<b>[Physician</b>	A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household;</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>
<b>[Policy</b>	A legal contract between the Policyholder and the Company which describes the terms and conditions of insurance subject to its provisions, limitations and exclusions.]
<b>Policyholder</b>	The entity to which the Policy is issued and will include any affiliate or subsidiaries or divisions shown in the "Eligibility for Insurance" section.
<b>[Rehabilitation Facility</b>	A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which: <ol style="list-style-type: none"> <li>1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation Inpatient care;</li> <li>2. is duly licensed by the appropriate government agency to provide such services; and</li> <li>3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission of Accreditation of Rehabilitation Facilities.</li> </ol> <p>A Rehabilitation Facility does not include institutions which provide only minimal care; custodial care; care for the terminally ill; part-time care; or services or facilities for drug abuse or alcoholism.]</p>
<b>[Related Stays</b>	Successive stays in a Hospital unless: <ol style="list-style-type: none"> <li>1. any stay after the first is necessitated by causes entirely unrelated to the causes of the earlier stay; or</li> <li>2. the stays are separated by at least {180 days}.]</li> </ol>
<b>[Schedule of Benefits</b>	A brief outline of the coverage and benefits provided by this Policy.]
<b>[Sickness</b>	A physical or mental illness [ including pregnancy]. Complications of

pregnancy are considered a Sickness.]

[Spouse[\*

**\*The term Spouse includes a Domestic Partner as defined.]**

The [Employee] [Member]'s lawful spouse [who is aged {any Age between 18 years and under Age 70.} [ who is a United States citizen or has a permanent Alien Registration Card.] [Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed by {or divorced or legally separated from} an [Employee] [Member].]]

[Termination Date

The date on which insurance ends as defined later in this Policy.]

[Terrorism or Terrorist Act

[Any hostile or violent act carried out by a group of persons having political or military goals but not operating on behalf of a foreign state and whose purpose is to compel an act or omission by any other person or governmental entity.]

*or*

**[Domestic Terrorism** means the unlawful use, or threatened use, of force or violence, by a group or individual based and operating entirely within the United States or Puerto Rico without foreign direction, committed against persons or property to intimidate or coerce: a government; the civilian population; or any segment thereof; in furtherance of political or social objectives.

**International Terrorism** means violent acts or acts dangerous to human life occurring inside or outside of the United States: that are a violation of the criminal laws of the United States or any state; or that would be a criminal violation if committed within the jurisdiction of the United States or any state. The acts are committed to: intimidate or coerce a civilian population; influence the policy of a government by intimidation or coercion; or affect the conduct of a government by assassination or kidnapping.

**International Terrorist Group** means any group: practicing; or that has significant subgroups that practice; international terrorism that has been designated as a foreign terrorist organization by the United States Department of State.]]

[Totally Disabled or Total Disability

Totally Disabled or Total Disability means [either]:

1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of: education; training; or experience; [or]
2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including: eating; transferring; dressing; toileting; bathing; and continence;, without human supervision or assistance.]

[We, Us, Our

Catlin Insurance Company, Inc.]

[You, Your

The [Employee] [Member] to whom the certificate is issued.]

## ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

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### **Policy Effective Date**

The Insurance Company agrees to provide Accident Insurance Benefits described in the Policy in consideration of: the Policyholder's application; and payment of the initial premium when due. Insurance coverage for the Policyholder begins on the Policy Effective Date shown on the Policy's first page [as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied].

### **Eligibility**

[An Employee] [A Member] becomes eligible for insurance under the Policy on the date: he meets all of the requirements of one of the covered classes; and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* [and is insured under the Core Plan]. [A Spouse and Dependent Children of an eligible [Employee] [Member] become eligible for any dependent insurance provided by the Policy on the later of: the date the [Employee] [Member] becomes eligible; and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of the Policy.] [No person may be eligible for insurance under the Policy as both [an Employee] [a Member] and a Spouse or Dependent Child at the same time.]

An [Employee] [Member] whose eligible class is changed after the Effective Date of his coverage shall become eligible under the new eligible class on the [first day of the month coinciding with or next following] the date of the change.

[The [Employee] [Member] Eligibility Waiting Period may differ for current and newly covered persons. ]

### **[Effective Date for Individuals**

Insurance becomes effective for an eligible [Employee] [Member] [who applies: within {31 days} of the date he becomes eligible; [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
2. [the date][the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date][the first of the month after] We receive and accept the [Employee's] [Member's] completed enrollment form during his lifetime.]

[We may, from time to time, require the [Employee] [Member] to re-enroll using forms supplied by Us to keep his insurance in force.}]

[Insurance becomes effective for [an Employee's] [a Member's] eligible Dependent Children if the [Employee] [Member] applies: within {31 days} of the date his Dependent Children become eligible;] [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
- [2. [the date] [the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
- [3. [the date] [the first of the month after] the Dependent Child meets the definition of Spouse or Dependent Child, as applicable;]
4. [the date] [the first of the month after] We receive the [Employee's] [Member's] completed enrollment form for Spouse and Dependent Child coverage, during each Dependent Child's lifetime.]

Insurance becomes effective for an eligible [Employee] [Member] who applies and agrees to make required contributions: within {31 days} of eligibility;] [ and subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date] [the first of the month after] We receive and accept the [Employee's] [Member's] completed enrollment form and the required first premium, during his lifetime.]

[Insurance becomes effective for [an Employee's] [a Member's] eligible Dependent Children [if the [Employee] [Member] applies and agrees to make required contributions: within {31 days} of the date his Dependent Children become eligible; [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under the Policy;
- [2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;]
3. [the date] [the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
- [4.] [the date] [the first of the month after] the Spouse or Dependent Child meets the definition of Spouse or Dependent Child, as applicable;
- [5.] [the date] [the first of the month after] We receive and accept a completed enrollment form for Spouse and Dependent Child coverage and the required first premium, during each dependent's lifetime.]

Insurance becomes effective for a newborn Dependent Child automatically from the moment of the child's live birth. Insurance for that Dependent Child automatically ends {31 days} later unless: the [Employee] [Member] has {a Spouse or other Dependent Children} insured under the Policy; or makes a request to cover the child and pays the required initial premium, during the child's lifetime.]

**Newborn Children:** [An Employee's] [A Member's] newborn child is automatically covered from the moment of birth until such child is 90 days old if all other eligible children are covered under the certificate prior to the birth of the newborn child. Coverage for newborns shall be the same as for all other covered Dependent Children. The [Employee] [Member] must notify the Company in writing within 90 days of such birth or before the next premium due date, whichever is later, and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

**Adopted Children:** An adopted child is automatically covered for the first 60 days from the date of the [Employee] [Member] filing a petition for adoption unless the petition is denied or dismissed. Coverage for such child will be the same as for all other covered Dependent Children. The [Employee] [Member] must: notify the Company in writing within 60 days of: filing the petition for adoption; and pay the required additional premium (if any); in order to have coverage for the adopted child continue beyond such 60 day period.

#### **[DEFERRED EFFECTIVE DATE**

##### **[Active Service**

The effective date of insurance will be deferred for any [Employee] [Member] [or any eligible Spouse or Dependent Child] who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of: the date he returns to Active Service; and the date coverage would otherwise have become effective.]

##### **[Late Enrollment**

If application for insurance is not made within {31 days} of the date a person is first eligible for coverage [or a Life Status Change] [or during an Annual Re-Enrollment], the Covered Person will be considered a late enrollee. Coverage for any late enrollee will become effective on the later of: the date We approve the required evidence of insurability and receive required premium; and the date coverage would otherwise have become effective.]

##### **[Replacement Coverage**

[An Employee] [A Member] [and any Spouse and Dependent Children] who were insured under a Prior Plan and who is a member of the class of individuals eligible for coverage under this Policy on the effective date of the Policyholder under the Policy will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; and
2. the amount of coverage provided under the Policy.

If the amount of coverage otherwise provided by the Policy is greater than the amount provided under the Prior Plan, the greater amount will become effective on the {first day of the month on or after, or first day of the Policy year on or after or date] the [Employee] [Member], [Spouse or Dependent Child] returns to Active Service.]

[If [an Employee] [a Member] is required to contribute to the cost of any portion of his [or his Dependent Children's] insurance and is not in Active Service on the effective date of the Policyholder under the Policy, coverage will terminate {31 days} after the [Employee] [Member] returns to Active Service unless he submits an enrollment form and the required initial premium. If the [Employee] [Member] selects the amount of benefit for which he is required to pay premium for himself [or any Dependent Children], the amount in effect under this provision will be the lesser of: the amount provided under the Prior Plan; and the smallest amount he may select under the Policy.]

### **[Annual Re-Enrollment**

[An Employee] [A Member] currently insured under {the voluntary Accident portion of} the Policy, and a person who is eligible but has not previously enrolled, may increase or become insured for coverage under the Policy during an annual re-enrollment period as agreed to by Us and the Policyholder. [An Employee] [A Member] who is insured under the Policy may also elect or increase coverage for his eligible Dependent Children.] Coverage elected during an Annual Re-Enrollment Period will become effective [, subject to the *Active Service* section of the *Deferred Effective Date* provision,] on [the Policy Anniversary following, or first day of the month following the] date We receive a request and any required premium payment.]

### **[Life Status Change**

A Life Status Change an event that the Policyholder determines qualifies [an Employee] [a Member] to [elect,] or increase accident insurance benefits [for himself and his Spouse and Dependent Children]. [Any change in benefit elections must be made within {31 days} of a Life Status Change.]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase his accident insurance include:

- [1. marriage];
- [2. loss of a spouse, whether by death, divorce, annulment or legal separation];
- [3. birth or adoption of a child, or acquiring a child through marriage]; and
- [4. an increase in cost or a significant reduction or loss of group accident benefits provided by a Spouse's Plan].]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase accident insurance for his Spouse and eligible Dependent Children include:

- [1. marriage];
- [2. birth or adoption of a child, or acquiring a child through marriage]; and
- [3. a significant reduction, increase in cost or loss of group accident benefits provided by a Spouse's Plan].]

Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the [{first of the month following the} Life Status Change [or the {first day of the month following the} date the [Employee] [Member] applies and agrees to make required contributions]].

[The Policyholder should seek advice of its tax advisors if [Employees] [Members] may contribute to the cost of any insurance provided by the Policy with earnings not subject to Federal Income Tax. We cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward cost of insurance.]]

### **Effective Date of Changes**

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by the Policy; or
2. a change in the [Employee's] [Member's] Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

### **TERMINATION OF INSURANCE**

The insurance on a Covered Person will end on the earliest date below:

1. the date the Policy or insurance for a covered class is terminated;
- [2. the date the Policyholder's coverage under the Policy ends;]
3. the next premium due date after the date the Covered Person is no longer in a covered class or satisfies eligibility requirements under the Policy;
4. the last day of the last period for which premium is paid;
- [5. the next premium due date after the Covered Person attains the maximum Age for insurance under the Policy, as shown in the *Schedule of Benefits*;]
- [6. with respect to a Spouse {or Dependent Child}, the date of the death of the covered [or the date of divorce from the covered [Employee] [Member], unless the Spouse elects to continue insurance, including insurance on Dependent Children.] See *Continuation of Insurance* section;]
- [7. the date that the plan of benefits under which the Covered Person is covered is terminated.]

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

#### **[CONTINUATION OF INSURANCE**

Insurance for the covered Spouse [and Dependent Children] may be continued if a covered Spouse's [and Dependent Children's] insurance would otherwise end because of death of or divorce from the covered [Employee] [Member]. The Covered Spouse must:

1. submit a written request for continued insurance to Us within {31, 60, 90 days} of the event; and
2. pay the required premium to the Policyholder, directly to Us.]

[Insurance continued under this provision may not exceed the amount of insurance in force on the day before insurance as a covered Spouse ended, nor may a Spouse add any Dependent Children for insurance.]

Premiums for insurance continued under this provision will start with: the Premium Due Date on; or next following the date of the event. If a Spouse does not: elect to continue insurance under this provision; or does not provide notification within the required time period; insurance will not be continued and any premium paid from the date of the event will be refunded. [However, if notification is not given to Us within the time period required in (1.) above, any return of premium will be limited to any excess paid in the last {six, 12 months}]

Any Continuation of Insurance is subject to Our continuing to offer insurance under the Policy to new applicants.]

#### **[CONTINUATION OF INSURANCE**

We will continue insurance under the Policy for a Spouse [and Dependent Children] of a covered [Employee] [Member] who dies, without payment of premium for {12 to 24 months}. The Spouse [and Dependent Children]: (a) must have been insured under the Policy on the date the [Employee] [Member] died; and (b) must continue to meet all other requirements for eligibility. Coverage continued under this provision will terminate on the earlier of: the end of {the 12<sup>th</sup> month}; and the date the Spouse [or any Dependent Child] ceases to meet all other requirements for eligibility.

#### **[Continuation for {Layoff, Leave of Absence or Family Medical Leave}**

Insurance for [an Employee] [a Member] {and covered Dependent Children} may be continued until the earliest of the following dates if: (a) [an Employee] [a Member] is on a temporary {layoff, an approved leave of absence or an approved family medical leave}; and (b) required premium contributions are paid when due.

1. [for a layoff, [{six months} after] the end of the month in which the layoff begins;]
2. [for an approved leave of absence: [{six months} after] the end of the month in which the leave begins;]
3. [for an approved family medical leave {12 weeks in a consecutive 12-month period.}]

[Such continuation will {run concurrently with, precede} a continuation during any other leave.]]

#### **[Continuation for Military Service**

If [an Employee] [a Member] begins a leave of absence to serve in the armed forces, insurance for the [Employee] [Member] {and his Covered Dependent Children} will continue until the earliest of the following dates, if the required premium is paid:

1. 18 months;
2. the day the [Employee] [Member] fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when coverage is continued under this provision:

1. [any change in benefits that occurs during the period of continuation will apply on the effective date of the change;]
2. [any Active Service requirement will be waived; ]
3. The [Employee] [Member] will be given credit for the time he was covered under the Policy prior to the leave.

If [an Employee] [a Member] does not continue coverage for himself [and his Dependent Children] during such leave and returns to [work] [membership]:

1. the [Employee] [Member] [and his Dependent Children] will be covered on the date the [Employee] [Member] returns to [work] [membership] from the leave. The [Employee] [Member] must return to [work] [membership] as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;
2. any portion of an eligibility waiting period that has not been completed will not be credited during the [Employee's] [Member's] leave.]]

## COMMON EXCLUSIONS

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In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

- [1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane];
- [2. commission or attempt to commit a felony or an assault];
- [3. commission of or active participation in: a riot; insurrection; or Terrorist Act];
- [4. {bungee jumping;}{ parachuting;}{ skydiving;}{parasailing;}{ hang-gliding}];
- [5. declared or undeclared war or act of war];
- [6. Terrorism [or Terrorist Acts]];
- [7. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as:
  - a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
  - c. a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent;] or flight in; boarding; or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    - [a. except as a fare-paying passenger on a regularly scheduled commercial airline];
    - [b. being flown by the Covered Person or in which the Covered Person is a member of the crew];
    - [c. being used for:
      - [i. crop dusting; spraying or seeding; giving and receiving flying instruction; fire fighting; sky writing; sky diving or hang-gliding; pipeline or power line inspection; aerial photography or exploration; racing; endurance tests; stunt or acrobatic flying]; or
      - [ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);]
    - [d. designed for flight above or beyond the earth's atmosphere];
    - [e. an ultra-light or glider];
    - [f. being used for the purpose of parachuting or skydiving];
    - [g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;]
- [9. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle];
- [10. participation in any motorized race or contest of speed];
- [11. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program];
- [12. Sickness; disease; bodily or mental infirmity; bacterial or viral infection or medical or surgical treatment thereof; except for any bacterial infection resulting from: an accidental external cut or wound; or accidental ingestion of contaminated food];
- [13. medical or surgical treatment; diagnostic procedure; administration of anesthesia; or medical mishap or negligence, including malpractice];
- [14. travel or activity outside the United States or Canada];
- [15. travel in any Aircraft owned; leased; or controlled by the Policyholder; or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year];
- [16. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred];
- [17. voluntary ingestion of any narcotic; drug; poison; gas; or fumes; unless: prescribed or taken under the direction of a Physician; and taken in accordance with the prescribed dosage];
- [18. injuries compensable under: Workers' Compensation law; or any similar law];
- [19. occupational injuries for which benefits are not paid under: the Workers' Compensation Law; or any similar law];
- [20. injuries that result from a non-occupational accident];
- [21. a Covered Accident that occurs while on active duty service in: the military; naval; or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium

paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days];

In addition, benefits will not be paid for:

- [22. services or treatment rendered by: a Physician; Nurse; or any other person who is:
  - a. employed or retained by the Policyholder;
  - b. providing: homeopathic; aroma-therapeutic; or herbal therapeutic services;
  - c. living in the Covered Person's household;
  - d. who is: a parent; sibling;, spouse; or child of the Covered Person];
- [23. any Hospital Stay or days of a Hospital Stay that are not appropriate for the condition and locality.]

## [CONVERSION PRIVILEGE]

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- [1. If the Covered Person's insurance or any portion of it ends for a reason other than: non-payment of premium; the Covered Person's Age; or those reasons described in Paragraph 2 below; the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated policy. The Covered Person may not apply for an amount greater than his coverage under this Policy [less the amount of any other group accident insurance for which he becomes eligible within 31 days after the date coverage under this Policy terminated.] The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

The Covered Person must apply for the individual policy within 31 days after his coverage under this Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk.

The individual policy or certificate will take effect on the day following the date coverage under the Policy ended. If the Covered Person dies during this 31-day period as the result of an accident that would have been covered under this Policy, We will pay as a claim under this Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Policy.

2. If the Covered Person's insurance ends because this Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Policy for at least five years, the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
- a. coverage under this Policy less any amount of group accident insurance: for which he is eligible on the date this Policy is terminated; or for which he became eligible within 31 days of such termination; or
  - b. {\$10,000}

## CLAIM PROVISIONS

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### **Notice of Claim**

Written {or authorized electronic/telephonic} notice of claim must be given to Us: within {31 days} after a Covered Loss occurs or begins; or as soon as reasonably possible. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given to Us: at Our Home Office in Houston, Texas; or such other place as We may designate for the purpose; or to Our authorized agent. Notice should include: the Policyholder's name and policy number; and the Covered Person's name; address; policy; and certificate number.

### **Claim Forms**

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written {or authorized electronic} proof of the nature and extent of the loss for which the claim is made.

### **[Claimant Cooperation Provision**

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

### **Proof of Loss**

Written {or authorized electronic} proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss; then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written {or authorized electronic} notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written {or authorized electronic} proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

[The Plan Administrator of the Policyholder's employee welfare benefit plan (the Plan) has selected the Insurance Company as the Plan fiduciary under federal law for the review of claims for benefits provided by the Policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion: to interpret the terms of the Plan documents; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by the Insurance Company in this capacity shall be final and binding on Participants and Beneficiaries of The Plan to the full extent permitted by law.]

The Insurance Company has no fiduciary responsibility with respect to the administration of The Plan except as described above. It is understood that the Insurance Company's sole liability to the Plan and to Participants and Beneficiaries under The Plan shall be for the payment of benefits provided under the Policy.]

### **Time of Payment of Claims**

We will pay benefits due under the Policy for any loss other than a loss for which the Policy provides any periodic payment immediately upon receipt of due written {or authorized electronic} proof of such loss. Subject to due written {or authorized electronic} proof of loss, all accrued benefits for loss for which the Policy provides periodic payment will be paid no later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

### **Payment of Claims**

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under the Policy, unless otherwise stated, will be payable to the covered [Employee] [Member], his estate, or the hospital or person rendering services upon request by the group Policyholder.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay {\$1,000 - \$5,000} to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability, unless, before payment is made, We have received at Our home office written notice by or on behalf of another person that the other person claims to be entitled to the payment or some interest in the Policy.

#### **[Payment of Claims to Foreign [Employees] [Members]**

The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered [Employees] [Members] whose place of [employment] [membership] is other than:

- {1. the United States of America;}
- {2. Puerto Rico; or}
- {3. the Dominion of Canada}.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under the Policy.]

#### **Physical Examination [and Autopsy]**

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

#### **Legal Actions**

No action at law or in equity may be brought to recover under the Policy less than 60 days after written {or authorized electronic} proof of loss has been furnished as required by the Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

#### **Beneficiary**

The beneficiary is the person or persons the [Employee] [Member] names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary [, or to make any assignment of rights or benefits permitted by the Policy.] [A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child.] [Any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child will be paid to the [Employee's] [Member's] estate.]

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the [Employee] [Member] has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the [Employee] [Member] dies while benefits are payable to him, We may make direct payment to [the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of the [Employee] [Member].]

Or

[the estate of the [Employee] [Member].]

**Recovery of Overpayment**

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount;
2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

## ADMINISTRATIVE PROVISIONS

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### **Premiums**

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for the Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. [If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day before the reduction took place.]

### **Changes in Premium Rates**

We may change the premium rates from time to time with at least {31 days} advance written notice to the Policyholder. No change in rates will be made until {12 months} after the Policy Effective Date. An increase in rates will not be made more often than once in {a 12-month period}. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of the Policy change;
- [2. the terms of the Policyholder's participation change;]
- [3.] a division, subsidiary, affiliated company or eligible class is added or deleted from the Policy;
- [4.] there is a change in the factors bearing on the risk assumed;
- [5.] any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

### **Payment of Premium**

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder.

If any premium is not paid on the Premium Due Date when due, the Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period section.

### **Grace Period**

[1.] {Policy}

A Policy Grace Period of {31 days} will be granted for payment of required premiums under the Policy. The Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time the Policy was in force.

[2. {Covered Person}

A Grace Period of {31 days} will be granted for payment of required premiums under the Policy. A Covered Person's insurance under the Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If: no such claims are incurred; and premium is not paid during the grace period; insurance will end on the last day of the period for which premiums were paid.]

## GENERAL PROVISIONS

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### **Entire Contract; Changes**

The Policy, including: the endorsements; amendments; and any attached papers; constitutes the entire contract of insurance. No change in the Policy will be valid until: approved by one of Our executive officers; and endorsed on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

### **Misstatement of Fact**

If the Covered Person has misstated any fact, all amounts payable under the Policy will be such as the premium paid would have purchased had such fact been correctly stated.

### **Certificates**

Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list: the benefits; conditions; and limits of the Policy. It will state to whom benefits will be paid.

### **Multiple Certificates**

The Covered Person may have in force only one certificate at a time under the Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

[A Covered Person is not eligible for insurance under more than {one certificate providing benefits for accident insurance under group policies issued by Us}. If premium is being paid for more than one such certificate, insurance will be in effect under the certificate with the earliest effective date and premiums paid for certificates which are not in effect will be refunded.]

### **Assignment**

*Option 1: Include if no rights and benefits are assignable:*

[The rights and benefits under the Policy may not be assigned and any attempt to assign will be void.]

*Option 2: Include when no assignment other than benefits that have become payable is permitted:*

[The rights and benefits provided by the Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.]

*Option 3: Include if assignment is permissible:*

[We will be bound by an assignment of a Covered Person's insurance under the Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while: the assignment remains in effect; and insurance under the Policy and the Covered Person's certificate remains in force. We will deal with the assignee as the owner or pledge of the Policy in accordance with the terms of the assignment until We have received at Our home office written notice of termination of the assignment or written notice by or on behalf of some other person claiming some interest in the Policy in conflict with the assignment.]

### **Incontestability**

1. Of The Policy or Participation Under The Policy  
All statements made by the Policyholder to obtain the Policy are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; or to deny the validity of the Policy or of participation under the Policy; unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause the Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from: the Covered Person's effective date of insurance; or from the effective date of increased benefits; no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

### **[Reporting Requirements**

The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. additional information required by Us.]

### **Policy Termination**

We may terminate coverage on or after [the first anniversary of the policy effective date]. The Policyholder may terminate coverage on any premium due date. Written {or authorized electronic} notice must be given at least {31 days} prior to such premium due date. [Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

### **[Reinstatement**

The Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are: written application of the Policyholder satisfactory to Us; and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid [, but not to any period more than {60 days} prior to the date of reinstatement.]]

### **Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such error or delay is found, We will adjust the premium fairly.

### **Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that apply to the Policy are automatically changed to satisfy the minimum requirements of such laws.

### **Policy Changes**

We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

### **Workers' Compensation Insurance**

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

### **Examination of the Policy**

This Policy will be available for inspection at the Policyholder's office during regular business hours.

### **Examination of Records**

We will be permitted to examine all of the Policyholder's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

## DESCRIPTION OF [COVERAGES] AND BENEFITS

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This Description of [Coverages and] Benefits Section describes the Accident [Coverages and] Benefits provided by the Policy. Benefit amounts; benefit periods; and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within the Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms; conditions; and limitations applicable to these [coverages and] benefits.

### [ACCIDENTAL DEATH BENEFIT

<b>Covered Loss</b>	We will pay the benefit shown in the <i>Schedule of Benefits</i> if {a Covered Person} dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the <i>Schedule of Benefits</i> ].
<b>Exclusions</b>	Exclusions that apply to this Benefit are specified in <i>Common Exclusions</i> Section.]

## [ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

### Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if {the Covered Person} suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].

[If {the Covered Person} sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable.] If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

### Definitions

[**Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.]

[**Loss of Sight** means the total, permanent loss of all vision in one eye which is irrecoverable by: natural; surgical; or artificial means.]

[**Loss of Speech** means total and permanent loss of audible communication which is irrecoverable by: natural; surgical; or artificial means.]

[**Loss of Hearing** means total and permanent loss of ability to hear any sound {in both ears} which is irrecoverable by: natural; surgical; or artificial means.]

[**Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand** means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).]

[**Loss of Toes** means complete Severance through the metatarsalphalangeal joint.]

[**Paralysis or Paralyzed** means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.]

[**Quadriplegia** means total Paralysis of both upper and both lower limbs.]

[**Hemiplegia** means total Paralysis of the upper and lower limbs on one side of the body.]

[**Paraplegia** means total Paralysis of both lower limbs or both upper limbs.]

[**Uniplegia** means total Paralysis of one upper or one lower limb.]

[**Coma** means a profound state of unconsciousness: which resulted directly and independently from all other causes from a Covered Accident;

and from which {the Covered Person} is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.]

**[Severance** means the complete and permanent separation and dismemberment of the part from the body.]

**Exclusions**

The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

### **[ADDITIONAL [ACCIDENTAL DEATH AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other {Accidental Death and Dismemberment} benefits payable.]

### **[ARMED FORCES COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if {the Covered Person} suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while he is on active duty in any Armed Forces.

**Exclusions**                    The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### **[EXPOSURE AND DISAPPEARANCE COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if {a Covered Person} suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If {the Covered Person} disappears and is not found within {one year} from the date of: the wrecking; sinking; or disappearance of the conveyance in which {the Covered Person} was riding in the course of a trip which would otherwise be covered under the Policy, it will be presumed that {the Covered Person's} death resulted directly and independently of all other causes from a Covered Accident.

**Exclusions**                    The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### **[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable subject to the following conditions if {the Covered Person} suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while {the Covered Person} is a member of the U.S. Military Reserve or National Guard.

While the Covered Person is a member of the U.S. Military Reserve or National Guard, coverage under the Policy will remain in force beyond the 31-day active duty training period and continue:

1.        during the Covered Person's initial training period;
2.        if the Covered Person is called to active duty [for a domestic emergency].

**Exclusions**                    The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### **[OWNED AIRCRAFT COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs: during travel or flight in; including getting in or out of; any Aircraft that is: owned; leased; operated; or controlled by the Policyholder {or its subsidiaries or affiliates}. A record of eligible Aircraft will be maintained by the Policyholder and

available for review by Us at any time during normal business hours. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to: breakdown; repair; servicing; loss; or destruction.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### [PILOT COVERAGE

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while: the Covered Person is flying as a licensed pilot [or member of the crew] of an Aircraft; and meets all of the following requirements:

- [1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by Us;]
- [2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by Us;]
- [3. completes and maintains a combined minimum of {200 hours} of military, private or professional logged flight hours;]
- [4. is flying as a pilot [or member of the crew] of an Aircraft traveling on or transacting business for the Policyholder . All trips must have been authorized in advance by the Policyholder;]
- [5. is flying as a pilot [or member of the crew] of an Aircraft [described below] or [on a list of eligible Aircraft maintained by the Policyholder, including a substitute Aircraft with no greater seating capacity while a [specified] or [listed] Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction;]
- [6. is flying as a pilot [or member of the crew] of an Aircraft that is [not] owned, leased, operated or controlled by the Policyholder;]
- [7. is not giving or receiving flight instruction.]

**[Description of Aircraft Covered** {xxxx will list: type of Aircraft; license number; and passenger seating capacity: Boeing 727; License # PA12345; passenger seating capacity: 45}]

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

### [WAR RISK COVERAGE

Benefits for {Accidental Death and Dismemberment} as shown in the *Schedule of Covered Losses*, will be payable, subject to the following conditions and exclusions, if a Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during war or acts of war that occur in:

- {1. a specifically described geographic area such as Saudi Arabia, Iran, Serbia}; or
- {2. a generally described geographic area such as worldwide, excluding the United States and its territories and possessions.}

The Policyholder may cancel this war risk coverage at any time by sending written notice to Us at Our home office address. Coverage will be canceled upon receipt of notice or a date specified by the Policyholder.

We may cancel this coverage at any time by providing written notice to the Policyholder at least {10 days} prior to termination of this coverage. Any unearned premium will be promptly returned to the Policyholder.

**Exclusions** This benefit does not provide coverage when a Covered Loss occurs:  
[1. in the United States and its territories and possessions; or]  
[2. in any nation of which the Covered Person is a citizen.]

[[Other} exclusions that apply to this coverage are in the *Common Exclusions* Section.]]

### **[ADDITIONAL ACCIDENT BENEFITS]**

[{Accidental Death and Dismemberment benefits} are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other {Accidental Death and Dismemberment benefit} payable.]

### **[ADDITIONAL OCCUPATIONAL BENEFIT]**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss which results directly and independently of all other causes from a Covered Accident that occurs while the covered [Employee] [Member] is on the Policyholder's premises and engaged in the course of his [job] [membership] [or on business travel pre-authorized by the Policyholder].

[Business travel begins at the actual start of a business trip that has been pre-authorized by the Policyholder, whether the trip starts at the covered [Employee's] [Member's]: home; place of work; or another place. Business travel coverage:

1. ends when the covered [Employee] [Member] arrives at his: home; or place of work; whichever happens first; and
2. is not in effect during the covered [Employee's] [Member's] Personal Deviation.]

[Business travel includes: riding in; or getting on or off of; an Aircraft, but only if:

1. the covered [Employee] [Member] is riding as a passenger only, and not as a pilot or member of the crew; and
2. the Aircraft is not being used for any of the following:
  - a. crop dusting, spraying or seeding;
  - b. fire fighting;
  - c. sky writing;
  - d. sky diving or hang gliding;
  - e. pipeline or power line inspection;
  - f. aerial photography or exploration;
  - g. racing;
  - h. endurance tests, stunt or acrobatic flying;
  - i. any operation which requires a special permit from the FAA, even if it is granted unless the permit is required only because of the territory flown over or landed on;
  - j. giving or receiving flying instruction.]

**Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs: prior to the end of the trip; [or within {one hour } before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]

- Exclusions** [Business travel coverage is not provided during:
1. normal commuting between the covered [Employee's] [Member's] home and place of work; or
  2. the covered [Employee's] [Member's] Personal Deviation {in excess of 30 days}.]
- [[Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT**

We will pay counseling sessions, up to the Maximum Benefit Amount shown in the *Schedule of Benefits* and subject to the following conditions and exclusions, when the Covered Person{and/or Immediate Family Member} requires bereavement and trauma counseling because the Covered Person suffered a Covered Loss that resulted directly and independently of all other causes from a Covered Accident. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within {one year} from [the date of the Covered Accident causing the Covered Loss];
2. the expense is charged for a bereavement or trauma counseling session for the Covered Person{and/or one or more of his Immediate Family Members};
3. counseling is provided under the care, supervision or order of a Physician;
4. a charge would have been made if no insurance existed.

**Definitions** For purposes of this benefit:

**Immediate Family Member** means a person who is related to the Covered Person in any of the following ways: Spouse; brother-in-law; sister-in-law; son-in-law; daughter-in-law; mother-in-law; father-in-law; parent (includes stepparent); brother or sister (includes stepbrother or stepsister); or child (includes legally adopted child or stepchild).

**Exclusions** Covered bereavement and trauma counseling benefits do not include any expense for which the Covered Person is entitled to benefits under any Workers' Compensation Act or similar law.

[[Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BOMB SCARE, BOMB SEARCH OR BOMB EXPLOSION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. the covered [Employee] [Member] is on the Policyholder's premises when the Covered Accident occurs;
2. the Covered Accident is caused by or results from a Bomb Scare, Search or Explosion, as defined below;
3. the covered [Employee] [Member] is an authorized participant of a team or squad engaged in a Bomb Search or related activity;
4. the Policyholder authorizes the covered [Employee's] [Member's] participation and sanctions the search.

**Definitions** For purposes of this benefit:

**Bomb** means any real or dummy explosive device placed with intent to: damage; scare; or cause injury.

**Scare** means any real or false report of a Bomb on the premises of the Policyholder.

**Search** means any organized search for a reported Bomb.

**Explosion** means any detonation of a Bomb on the Policyholder's premises which appears to have been intended to cause injury or unlawful property damage, whether or not the presence of the Bomb was reported before detonation. [It does not include: any act of declared or undeclared war in the United States of America or Canada; or acceptance of known explosives as cargo.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section. ]

#### **[BULLETPROOF VEST BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] {who is Age 18 or older} is on official duty for the Policyholder and is shot during a Covered Accident while wearing a Bulletproof Vest and:

1. the Bulletproof Vest fails to prevent the bullet's penetration through the vest; and
2. such penetration results, directly and independently of all other causes, in {a Covered Loss, Covered Injury}.

**Definition** For purposes of this benefit:

**Bulletproof Vest** means a protective vest designated as { Threat Level II-A; Threat Level II; or Threat Level III-A} [manufactured by a vendor designated by the Policyholder] and [purchased not more than {five years} before the Covered Accident.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[BURIAL AND CREMATION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, for burial or cremation of the covered [Employee] [Member] who dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[BUSINESS TRAVEL BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a business trip authorized in advance by the Policyholder. The Covered Loss must be sustained:

1. in the course of the covered [Employee's] [Member's] [job] [membership];
- [2. away from the premises of the Policyholder in the covered [Employee's] [Member's] city of permanent assignment].

Coverage will begin at the actual start of a business trip authorized by the Policyholder. It does not matter if the trip starts at the covered [Employee's] [Member's]: home; place of work; or any other place. Coverage will end when the covered [Employee] [Member] arrives at: his home; or place of work; whichever happens first.

**[Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs prior to the end of the trip [or within {one hour} before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]]

**Exclusions** Coverage for business travel is not provided during [any of the following]:

1. normal commuting between the covered [Employee's] [Member's] home and place of work;
- [2. travel in an Aircraft: owned; leased; operated; or controlled by the Policyholder;]
3. travel to another location where the [Employee] [Member] is expected to be assigned for more than {60 days} by the Policyholder;
4. a covered [Employee's] [Member's] Personal Deviation [in excess of {31 days}].

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

**[CHILD CARE CENTER BENEFIT**

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered [Employee] [Member] [Spouse] results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. coverage for his Dependent Children was in force on the date of the Covered Accident causing his death: and
2. one or more surviving Dependent Children is under Age {13}; and
  - [a. was enrolled in a Child Care Center on the date of the Covered Accident; or]
  - [b. enrolls in a Child Care Center within {90 - 365 days} from the date of the Covered Accident].

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each {12 month} period that begins after the date of the covered [Employee's] [Member's] [Spouse's] death. A claim must be submitted to Us at the end of each {12 month} period [with proof of enrollment and attendance]. A {12 month} period begins:

- [1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered [Employee's] [Member's] [Spouse's] death; or]
2. on the first of the month following the covered [Employee's] [Member's] [Spouse's] death, if the Dependent Child was enrolled in a Child Care Center before the covered [Employee's] [Member's] [Spouse's] death.

Each succeeding {12 month} period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

**Definitions** For purposes of this benefit:

**Child Care Center** is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

[**Surviving Spouse** will include the covered [Employee] [Member] and covered Spouse.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[COMMON CARRIER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Common Carrier** means:

1. a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or a similar air transport service of another country.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[EMERGENCY ROOM BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Emergency Room Treatment due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Definition** For purposes of this benefit:

**Emergency Room** means a trauma center or a special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[ESCALATOR BENEFIT**

We will increase the Covered Person's Principal Sum by {the dollar amount or the percentage of Principal Sum} shown on the *Schedule of Benefits*, subject to the following conditions and exclusions. [The Covered Person must be under Age {55; 60} to be eligible for this benefit.] [Benefit amounts for {a covered Spouse, Dependent Child} will not be increased.]

[The Principal Sum used to calculate this benefit:

1. will be the amount in force when the Covered Person first becomes insured for this benefit;
2. will not compound previous Escalator benefit amounts.]

Increases will become effective on each {Policy or certificate anniversary} after the Covered Person has been insured for {12 consecutive months}. Benefit increases will occur automatically at the end of each {12 month} period, for a maximum of {five years}.

[Increases provided by this benefit will be calculated separately for each additional Principal Sum the Covered Person elects. The total amount of all increases will not exceed the highest amount shown in the *Schedule of Benefits*.

[If the Covered Person's Principal Sum is reduced, any increases provided under this benefit will be reduced in the same proportion.]

**Exclusions** [This benefit will not apply to any *Bonus Benefit*.]

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT**

We will pay the amount shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault as described below. [A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid.] [The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder.]

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

[We will pay a Hospital Stay Benefit, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

1. the Covered Person is covered for Hospital Stay benefits under the Policy;]
2. the Hospital Stay begins within {30 days} of the violent crime/felonious assault;
3. the Hospital Stay is at the direction and under the care of a Physician;]
4. the Covered Person provides proof satisfactory to Us that his Hospital Stay was necessitated to treat Covered Injuries sustained in a Covered Accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Definitions** For purposes of this benefit:

**Family Member** means the Covered Person's parent; step-parent; Spouse; or former Spouse; son; daughter; brother; sister; mother-in-law; father-in-law; son-in-law; daughter-in-law; brother-in-law; sister-in-law; aunt; uncle; cousins; grandparent; grandchild; and stepchild.

**Fellow [Employee] [Member]** means [a person employed by [a member of] the same Policyholder as the Covered Person or by an Entity that is an affiliated or subsidiary entity. It shall also include any person who was so [employed] [qualified as a member], but whose [employment] [membership] was terminated not more than {45 days} prior to the date on which the defined violent crime/felonious assault was committed.

**Member of the Same Household** means a person who maintains residence at the same address as the Covered Person.

**Exclusions** Benefits will not be paid for treatment of any Covered Injury sustained or Covered Loss incurred during any:

1. violent crime or felonious assault committed by the Covered Person; or
2. felonious assault or violent crime committed upon the Covered Person by: a Fellow [Employee] [Member]; Family Member; or Member of the Same Household.

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

## [HIV OCCUPATIONAL ACCIDENT BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the covered [Employee] [Member] suffers a Covered Injury resulting, directly and independently of all other causes, from a Covered Accident. Such Covered Accident must: occur during the performance of Occupational Duties; and result in the covered [Employee] [Member] acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within {one year} of the Covered Injury.

In order to receive this benefit, the covered [Employee] [Member] must satisfy all of the following:

1. submit a Workers' Compensation Injury report to the Policyholder, within {48 hours} of the Covered Accident that occurs during the performance of Occupational Duties;
2. test negative for Human Immunodeficiency Virus (HIV) antibodies within {48 hours} of such Covered Accident;
3. test positive for Human Immunodeficiency Virus (HIV) antibodies in a subsequent Blood Test within {one year} of the date of the Covered Accident.

**Definitions** For purposes of this benefit:

**Occupational Duties** means the performance of normal work duties on behalf of the Policyholder.

**HIV** means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

**Blood Test** means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by Us.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay the Covered Home Alteration and Vehicle Modification Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss, other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. the Covered Person requires home alteration or vehicle modification within {one year} of the date of the Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOSPITAL STAY BENEFIT**

We will pay the {daily, monthly} benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires a Hospital Stay due to {a Covered Loss} resulting directly and independently of all other causes from a Covered Accident.

The Hospital Stay must meet all of the following:

1. be at the direction and under the care of a Physician;
2. begin within {30 days} of the Covered Accident;
- [3. begin while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay that continues after the end of the Benefit Waiting Period as shown in the *Schedule of Benefits*. Benefits will be paid retroactively to the first day of the Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[PRIVATE PASSENGER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident while: driving; riding as a passenger in; or getting in or out of; a Private Passenger Automobile.

*Include if Accidental Death and Dismemberment Benefits are not included in the issued policy.*

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Private Passenger Automobile** means a validly registered; four wheel private passenger car (including Policyholder-owned cars); campers; motorized golf carts; motor homes; non-motorized bicycles; non-motorized adult tricycles; station wagons; sport utility vehicles; pick-up trucks; and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a: taxicab; bus; or other public conveyance will not be considered a Private Passenger Automobile.

Any vehicle not defined above will not be considered a Private Passenger Automobile.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[REHABILITATION BENEFIT**

We will pay the Rehabilitation Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person requires rehabilitation after sustaining a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Covered Person must require Rehabilitation within {two years} after the date of {the Covered Accident, Covered Loss}.

**Definition** For purposes of this benefit:

**Rehabilitation** means {medical services; supplies; or treatment; or Hospital confinement (or part of a Hospital confinement)} that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the Covered Person's Covered Loss;
2. meet generally accepted standards of medical practice;
3. are performed under: the care; supervision; or order of a Physician;
4. prepare the Covered Person to return to his or any other occupation.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[SEATBELT [AND AIRBAG] BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a

passenger in an Automobile. [An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).]

Verification of proper use of the seatbelt at the time of the Covered Accident [and that the Supplemental Restraint System properly inflated upon impact] must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

[If: such certification or police report is not available; or it is unclear whether the Covered Person was wearing a seatbelt [or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System]; We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.]

[In the case of a child, seatbelt means: a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration; properly secured; and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.]

**Definitions** For purposes of this benefit:  
[if *airbag benefit* is included: **Supplemental Restraint System** means an airbag that inflates upon impact for added protection to the head and chest areas.]

**Automobile** means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to: a sedan; station wagon; sport utility vehicle; or a motor vehicle of the pickup; van; camper; or motor-home type. Automobile does not include: a mobile home; or any motor vehicle which is used in mass or public transit.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[SPECIAL EDUCATION BENEFIT**

We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for [each qualifying Dependent Child] [and][a surviving covered Spouse] who {is/are} insured under the covered [Employee's] [Member's] certificate on the date he dies {or if he has been Totally Disabled during the Benefit Waiting Period for Permanent Total Disability benefits.] The [Employee's] [Member's] death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit [or Permanent Total Disability Benefits] {is, are} payable under the Policy. This benefit is subject to the conditions and exclusions described below.

[A qualifying Dependent Child must:

1. a. [be enrolled as a full-time student in an accredited school of higher learning beyond the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident]; *or*  
b. [be at the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident and then enroll as a full-time student at an accredited school of higher learning within {365 days} from the date of the Covered Accident and continue his education as a full-time student.]
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in the Policy;

2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying surviving Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in the Policy;
2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying surviving Spouse must:

1. enroll in any accredited school for the purpose of retraining or refreshing skills needed for employment within {one year} of the date of the covered [Employee's] [Member's] Covered Accident;
2. remain enrolled in such accredited school; and
3. incur expenses: payable directly to; or approved by; such school.]]

Payments will be made to each qualifying Dependent Child [or to the child's legal guardian, if the child is a minor] at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits], if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

[If no Dependent Child qualifies for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

[Payments will be made to the surviving Spouse at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Spouse's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the date the surviving Spouse enrolls in an accredited school for the first time following the date the [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits]. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.]]

[If a surviving Spouse does not qualify for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[TOTAL DISABILITY WEEKLY INCOME BENEFIT**

We will pay weekly benefits shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, to the Covered Person whose Total Disability results: directly and independently of all other causes from; and within {31 days} of; a Covered Accident. Weekly disability benefits will begin when the Totally Disabled Covered Person satisfies the Benefit Waiting Period shown in the *Schedule of Benefits* and will end on the earliest of the date he:

1. dies;
2. is no longer Totally Disabled;
3. fails to provide certification by a Physician that he remains Totally Disabled;

4. is eligible to receive [Accidental Death and Dismemberment benefits] [Permanent Total Disability benefits] for the same Covered Accident];
5. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits*.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[WAIVER OF PREMIUM BENEFIT**

We will waive premiums, beginning with those due on and after the end of the Benefit Waiting Period, for a covered [Employee] [Member] {and}{Spouse} who:

- a. becomes Totally Disabled [within {30 days} of] [after suffering] a Covered Loss that results directly and independently of all other causes from a Covered Accident; and
- b. satisfies all of the following conditions:
  1. Total Disability must begin before the covered [Employee's] [Member's] {Spouse's} {60th} birthday;
  2. We must receive proof satisfactory to Us that Total Disability was continuous during the Benefit Waiting Period;
  3. insurance under the Policy remains in force during the Benefit Waiting Period.

The covered [Employee] [Member] must submit satisfactory proof of continuous Total Disability to Us no more than {three to 12 months} after the date he [became Totally Disabled] [satisfies the Benefit Waiting Period]. Proof of continuing Total Disability must be submitted to Us during the last {three months} of each year. We may have the covered [Employee] [Member] {Spouse} examined as often as reasonably necessary while Totally Disabled, but not more than once a year after two years.

The amount of insurance for which premiums will be waived is the amount in force on the date the covered [Employee] [Member] {Spouse} became Totally Disabled. This amount will be subject to any age reductions applicable during the Benefit Period. Any increases in coverage that would have occurred if the covered [Employee] [Member] {Spouse} were not Totally Disabled will be deferred, as described in the *Deferred Effective Dates* provision of the *Eligibility and Effective Date* section of the Policy.

Premiums will cease to be waived on the earliest of the following dates:

1. the premium due date following the date the covered [Employee] [Member] {Spouse} ceases to be Totally Disabled;
2. the date the covered [Employee] [Member] {Spouse} refuses to be examined or fails to provide required proof of continuing Total Disability;
3. the premium due date following the end of the Benefit Period shown in the *Schedule of Benefits*.

When premiums cease to be waived as described above, insurance provided under the Policy will continue as long as premiums are paid when due.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**ARKANSAS GROUP ACCIDENT INSURANCE ENROLLMENT APPLICATION**

**Catlin Insurance Company, Inc.**

For information and customer service call: {Catlin Insurance Company, Inc.} Toll Free # {1-877-

CATLIN-US (1-877-228-5468)}

All info must be completed by the applicant.

He/she must sign and date this form.

This form cannot be considered unless received within 10 days of the date it is dated.

Can use to insert Catlin logo

**[ADMINISTRATOR RETURN ADDRESS]**

**Important:** Please enter all dates in mm/dd/yyyy format.

**POLICYHOLDER USE (MANDATORY DATA NEEDED):**

In order to process this application, the Policyholder must complete this information.

**POLICYHOLDER**

<b>CLASS</b>	<b>LOCATION/PAYCODE #</b>	<b>DATE OF BIRTH</b>	<b>ANNUAL SALARY</b>
_____	_____	_____	_____

Please print (preferably in black ink).

**REASON FOR REQUEST:**     **NEW HIRE**                       **INITIAL ENROLLMENT**  
 **ONGOING ENROLLMENT**             **LATE ENTRANT**

<b>[EMPLOYEE] [MEMBER] SECTION</b>			
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. (Check One)			
Name _____	Social Security # _____	Birthdate _____	
Address _____		City _____	State _____ Zip _____
Work Phone _____	Home Phone _____	ID Number _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

<b>COMPLETE IF ELECTING SPOUSE/[DOMESTIC PARTNER COVERAGE]</b>	
I am currently married and my date of marriage is: _____ [- <input type="checkbox"/> I currently have an eligible Domestic Partner.*] or-	
<b>Spouse/[Domestic Partner] Information</b>	Name (First) _____ (Last) _____ Social Security # _____ Birthdate _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
*[In order to be eligible for Domestic Partner coverage, you must have a Domestic Partner Affidavit or its equivalent on file with the Policyholder, and accepted by the Insurance Company. If you do not currently have one on file with the Policyholder, one will be made available through the Policyholder.]	

<b>BENEFIT SECTION [OPTION 1]</b>	
<b>Applicant</b>	<b>Amount*</b>
[Employee] [Member]	

<b>BENEFIT SECTION [OPTION 2]</b>				
<b>Applicant</b>	<b>Accept</b>	<b>Reject</b>	<b>Requested Amount</b>	<b>Maximum Coverage*</b>
[Employee] [Member]			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
Spouse			Number of [\$1000 - \$10,000] Units:	\$
Dependent Children			Number of [\$1000 - \$10,000] Units:	\$

<b>BENEFIT SECTION [OPTION 3]</b>				
<b>Applicant</b>	<b>Accept</b>	<b>Reject</b>	<b>Requested Amount</b>	<b>Maximum Coverage*</b>
[Employee] [Member] Only*			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary	\$
Family Plan:*				
[Employee] [Member] Spouse (no dependent children)			<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 10x] Salary [0 - 100%] of [Employee's] [Member's] Benefit	\$

Spouse (w dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (no Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (w Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$

**BENEFIT SECTION [OPTION 4]**

<i>Applicant</i>	<i>Accept</i>	<i>Reject</i>	<i>Requested Amount</i>	<i>Maximum Coverage*</i>
[Employee] [Member]			Number of [\$1000 - \$10,000] Units:	\$
Spouse			Number of [\$1000 - \$10,000] Units:	\$
Dependent Children			Number of [\$1000 - \$10,000] Units:	\$

**BENEFIT SECTION [OPTION 5]**

<i>Applicant</i>	<i>Accept</i>	<i>Reject</i>	<i>Requested Amount</i>	<i>Maximum Coverage*</i>
[Employee] [Member] Only*			Number of [\$1000 - \$10,000] Units:	\$
Family Plan:*				
[Employee] [Member]			Number of [\$1000 - \$10,000] Units:	\$
Spouse (no dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Spouse (w dependent children)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (no Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$
Dependent Children (w Spouse)			[0 – 100%] of [Employee's] [Member's] Benefit	\$

\* All insurance is subject to age-based reduction schedule:

† Medical underwriting of applicants is required for certain amounts of insurance.

**BENEFICIARY**

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and dependent child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

<i>Insured</i>	<i>Beneficiary(ies)</i>	<i>Percentage</i>	<i>Social Security #</i>	<i>Date of Birth</i>	<i>Relationship</i>
[Employee] [Member] (Policyholder) Paid Coverage)					
[Employee] [Member] ([Employee] [Member]) Paid Coverage)					

**◆◆◆ACCEPTANCE/DECLINATION◆◆◆**

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.



Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Sign Here**

**Important: You must sign and date the Agreements section.**

**Applicant's  
Name**

**Social Security  
#**

**◆◆◆ AGREEMENTS ◆◆◆**

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am an active Employee or an active Member on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.



**Sign Here**

***[Employee's] [Member's] Signature***

***Month/Day/Year***

**Applicant's  
Name**

**Social Security  
#**

**◆◆◆ AUTHORIZATION TO RELEASE INFORMATION ◆◆◆**

I hereby authorize any: physician; medical practitioner; Hospital; clinic or other medical related facility; insurance company; insurance support organization; business partner, pharmacy, government agency; group policyholder; employer; benefit plan administrator; the Medical Information Bureau; the Department of Motor Vehicle Registration; and paramedical facility, to provide Catlin Insurance Company, Inc. or to any: agent; attorney; consumer reporting agency; or independent administrator; including: medical record retrieval services; or pharmaceutical services; acting on Catlin Insurance Company or its reinsurers' behalf, information concerning: advice; care; or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to: medical history; medical conditions; treatment; hospitalizations or confinements; ailments; and/or drug; alcohol; or tobacco usage of the Applicant(s). It is understood that Catlin Insurance Company, Inc. underwriters; claim examiners; reinsurers; attorneys; or the medical director may disclose such health information to the aforementioned parties for purposes of: underwriting; compliance; record clarification or explanation; or in response to: litigation; summons; or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- 1) such information will be used by Catlin Insurance Company, Inc. for underwriting and insurability determinations;
- 2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
- 3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- 4) any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Underwriting Department of Catlin Insurance Company, Inc. [1330 Post Oak Boulevard, Suite 2325, Houston, TX 77056]. *I may inspect or copy any information used or disclosed under this authorization, if signed.*



**Sign Here**

***Applicant's Signature***

***Month/Day/Year***

**Applicant's  
Name**

**Social Security  
#**

**Catlin Insurance Company, Inc.**  
**Statutory Home Office: 1330 Post Oak Boulevard, Suite**  
**2325, Houston, TX 77056**  
**Administrative Office: 3340 Peachtree Road N.E., Suite**  
**2950, Atlanta, GA 30326**  
**A Stock Insurance Company**

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**ARKANSAS GROUP ACCIDENT POLICY**

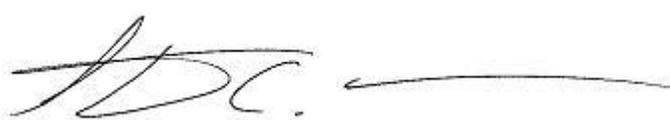
**POLICYHOLDER:** {ABC Company, Inc.}  
**POLICY NUMBER:** {Specimen}  
**POLICY EFFECTIVE DATE:** {January 1, 2008}  
**POLICY ANNIVERSARY DATE:** {January 1}  
**STATE OF ISSUE:** {Any State}

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 AM on the Policy Effective Date shown above at the Policyholder's address. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

**THIS IS A GROUP ACCIDENT ONLY INSURANCE POLICY.**  
**IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.**

**THIS IS A LIMITED POLICY.**  
**PLEASE READ IT CAREFULLY.**



Secretary



President

Countersigned \_\_\_\_\_

Where Required By Law

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## **[SCHEDULE OF COVERED AFFILIATES**

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The following affiliates are covered under this Policy on the effective dates listed below.

AFFILIATE NAME	LOCATION	EFFECTIVE DATE
{ABC Company}	{ city, state}	{January 1, 2001}}

## SCHEDULE OF BENEFITS

***This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.***

**The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the *Description of Coverages and Benefits* Section for full details.**

<b>Effective Date Policyholder:</b>	
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<b>[Minimum Participation Requirements</b>	Percentage {0% - 100% of eligible [Employees] [Members]}
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### **[Covered Classes**

Class 1	All full-time Employees of the Policyholder working at least [20-40] hours per week.
Class 2	All part-time Employees working at least [0-40] hours per week.
Class 3	All active Members of the Policyholder.
Class 4	All Spouses and Dependent Children of Class 1, 2, or 3. ]

### **[Eligibility Waiting Period**

The Eligibility Waiting Period is the period of time the [Employee] [Member] must be in a Covered Class to be eligible for coverage. [It will be extended by the number of days the [Employee] [Member] is absent from scheduled work.]

For [Employees] [Members] added [{31 days} or more] before the Policy Effective Date:	{No Waiting Period}
For [Employees] [Members] added [less than {31 days} before, or] after the Policy Effective Date:	{One month; 30 days; 31 days]}

### **[Time Period for Loss**

[Any Covered Loss must occur within:	{90 - 365 days} of the Covered Accident]}
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**This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Covered Person's] Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.**

### **[ACCIDENTAL DEATH BENEFIT**

[[Employee] [Member] Principal Sum:	{ \$0 - \$2,000,000 in increments of \$500 }
[Spouse Principal Sum:	{ \$0 - \$2,000,000 in increments of \$500 }
[Dependent Child(ren) Principal Sum:	{ \$0 - \$1,000,000 }

### **[Age Reductions**

A Covered Person's Principal Sum will be reduced by the percentage shown below:

<b>Age</b>	<b>Percentage of Benefit Amount</b>
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member].]

**[Aggregate Limit of Liability]**

Each Covered {Aircraft} Accident	{ \$0 - \$5,000,000 for all Covered Persons }
Applies to:	{ Accidental Death and Dismemberment Benefits or Accidental Death Benefits or All coverage and benefits provided by this Policy }

If this aggregate amount does not allow all Covered Persons to be paid the amounts the specified benefits otherwise provide, the amount paid for each Covered Person is the proportion each Loss bears to the Aggregate Limit of Liability. [Covered Aircraft Accident means a Covered Accident involving a scheduled or chartered flight in an Aircraft.]

**[ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS]**

[[Employee] [Member] Principal Sum:	{ \$0 - \$2,000,000 in increments of \$500 }
[Spouse Principal Sum:	{ \$0 - \$2,000,000 in increments of \$500 }
[Dependent Child(ren) Principal Sum:	{ \$0 - \$1,000,000 }

**SCHEDULE OF COVERED LOSSES**

<b>Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{100% of the Principal Sum}}
[Loss of Two or More Hands or Feet	{100% of the Principal Sum}}
[Loss of Sight of Both Eyes	{100% of the Principal Sum}}
[Loss of Speech and Hearing (in both ears)	{100% of the Principal Sum}}
[Loss of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Sight in One Eye	{50% of the Principal Sum}}
[Severance and Reattachment of One Hand or Foot	{50% of the Principal Sum}}
[Loss of Speech	{50% of the Principal Sum}}
[Loss of Hearing (in both ears)	{50% of the Principal Sum}}
[Loss of Thumb and Index Finger of the Same Hand	{25% of the Principal Sum}}
[Loss of all Four Fingers of the Same Hand	{25% of the Principal Sum}}
[Loss of all the Toes of the Same Foot	{20% of the Principal Sum}}

**[Age Reductions]**

A Covered Person's Principal Sum will be reduced by the percentage shown below:

<b>Age</b>	<b>Percentage of Benefit Amount</b>
{70 but less than 75}	{65%}
{75 but less than 80}	{45%}
{80 but less than 85}	{30%}
{85 or over}	{15%}

Each succeeding percentage reduction will apply to the Principal Sum in force on the day before the Covered Person attains the Age specified in the table above.

[A covered Spouse's Principal Sum will reduce based on the Age of the covered [Employee] [Member].]

**[ADDITIONAL ACCIDENTAL DEATH [AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverage. Any benefits payable under them are as shown in the *Schedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.]

<b>[ARMED FORCES COVERAGE]</b>	Principal Sum multiplied by the percentage
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	applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[EXPOSURE AND DISAPPEARANCE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[OWNED AIRCRAFT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[PILOT COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
<b>[WAR RISK COVERAGE</b>	Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]

**[ADDITIONAL ACCIDENT BENEFITS ]**

[Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other {Accidental Death and Dismemberment benefits} payable.]

<b>[ADDITIONAL OCCUPATIONAL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT</b>	
Benefit Amount	{\$75 per session}
Maximum Number of Sessions	{10 sessions}
Maximum Benefit Per Covered Accident	[\$750]

<b>[BOMB SCARE, BOMB SEARCH, OR BOMB EXPLOSION BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[BULLETPROOF VEST BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[BURIAL AND CREMATION BENEFIT</b>	[\$0 - \$5,000]
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<b>[BUSINESS TRAVEL BENEFIT</b>	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses.</i> ]
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<b>[CHILD CARE CENTER BENEFIT</b>	
Benefit Amount	[\$0 - \$3,000 per year}
Maximum Benefit Period	{to Age {13} for each surviving Dependent Child}]

<b>[COMMON CARRIER BENEFIT</b>	{50%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the
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<i>Schedule of Covered Losses</i>	
<b>[Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{\$10,000}}
[Loss of Two or More Hands or Feet	{\$10,000}}
[Quadriplegia	{\$10,000}}
[Hemiplegia	{\$5,000}}
[Uniplegia	{\$5,000}}
[Coma	{\$5,000}}]]

<b>[EMERGENCY ROOM BENEFIT</b>	
Benefit Amount	{\$200}
Maximum Payable Visits per Calendar Year	{5}
Maximum Benefit Per Covered Accident	{\$1,000}}

<b>[ESCALATOR BENEFIT</b>	
Periodic Increase	{10% of the Principal Sum}
Frequency of Increases	{Annually}
Maximum Total Increase	{50% of the Principal Sum}}

<b>[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT</b>	
Accidental Death and Dismemberment Benefit	{10%} multiplied by the portion of the Principal Sum applicable to the Covered Loss, as shown in the <i>Schedule of Covered Losses</i> .
Hospital Stay Benefit	{\$100 per day}
Maximum Benefit Period	{730 days per Hospital Stay per Covered Accident}}

<b>[HIV OCCUPATIONAL ACCIDENT BENEFIT</b>	
	{25%} of the Principal Sum [subject to a maximum of {\$100,000}}]

<b>[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT</b>	
Benefit	{10% of the Principal Sum subject to a maximum of \$25,000}}

<b>[HOSPITAL STAY BENEFIT</b>	
Benefit Amount	{\$200 per day}
Maximum Benefit Period	{730 days per Hospital Stay per Covered Accident}
Benefit Waiting Period	{7 days}}

<b>[PRIVATE PASSENGER BENEFIT</b>	
	{30% of the Principal Sum} <i>not applicable if stand-alone benefit</i>
<b>[Covered Loss</b>	<b>Benefit</b>
[Loss of Life	{\$10,000}}
[Loss of Two or More Hands or Feet	{\$10,000}}
[Quadriplegia	{\$10,000}}
[Hemiplegia	{\$5,000}}
[Uniplegia	{\$5,000}}
[Coma	{\$5,000}}]]

<b>[REHABILITATION BENEFIT</b>	
Benefit per Covered Accident	{10% of the Principal sum, subject to a maximum of

	\$250,000}]
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<b>[SEATBELT [AND AIRBAG] BENEFIT</b>	
[Seatbelt Benefit	{10%} of the Principal Sum [subject to a Maximum Benefit of {\$25,000}]
[Airbag Benefit	{5%} of the Principal Sum [subject to a Maximum Benefit of {\$25,000}]
[Default Benefit	{\$1,000}]

<b>[SPECIAL EDUCATION BENEFIT</b>	
Surviving Dependent Child Benefit	{5%} of the Principal Sum [subject to a Maximum Benefit of {\$7,500}]
[Surviving Spouse Benefit	{5%} of the Principal Sum [subject to a Maximum Benefit of {\$7,500}]
Maximum Number of Annual Payments	
[For Each Surviving Dependent Child	{4}]
[For Surviving Spouse	{4}]
Default Benefit	{\$1,000}]

<b>[TOTAL DISABILITY WEEKLY INCOME BENEFIT</b>	
Weekly Benefit Amount	{\$500}
Benefit Waiting Period	{7 days}
Maximum Benefit Period per Covered Accident	{26 weeks}]

<b>[WAIVER OF PREMIUM BENEFIT</b>	
Benefit Waiting Period	{9 months}
Benefit Period	
<u>Age when Total Disability Begins</u>	<u>Benefit Period</u>
Less than 60	{to 65 <sup>th</sup> birthday}
60 and later	{60 months}]

**[INITIAL PREMIUM RATES**

Premium Rate:	{Premium amounts will vary based on the plan of benefits: \$123.45} per {covered [Employee] [Member], covered [Employee] [Member] and covered Spouse, per Dependent Child, per month}
Mode of Premium Payment:	{Monthly; Quarterly; Semi-Annually; Annually}
Contributions:	The cost of coverage is paid by the {Policyholder; Policyholder and Covered Person}
Premium Due Dates:	The Policy Effective Date and the first day of each succeeding {interval}[month].

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of this Policy. [Each Covered Person's premiums are based on his Age and will increase on the next premium due date after the Covered Person enters a new Age bracket.]

## GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

<b>[Active Service</b>	<p>[An [Employee] [Member] will be considered in Active Service with the Policyholder on any day that is either of the following:</p> <ol style="list-style-type: none"> <li>1. [one of the Policyholder's scheduled work days on which the [Employee] [Member] is performing his regular duties on a full-time basis, either at one of the Policyholder's usual places of business or at some other location to which the Policyholder's business requires the [Employee] [Member] to travel; or]</li> <li>2. [a scheduled holiday; vacation day; or period of approved paid leave of absence; other than sick leave, only if the [Employee] [Member] was in Active Service on the Preceding scheduled workday; or]</li> <li>3. [a day on which the Member meets all the conditions of membership of the Policyholder.]]</li> </ol> <p>[An eligible Dependent Child or eligible Spouse of the [Employee] [Member] is considered in Active Service if he is none of the following:</p> <ol style="list-style-type: none"> <li>1. an Inpatient in a Hospital; or receiving Outpatient care for chemotherapy or radiation therapy;</li> <li>2. Confined at home under the care of Physician for Sickness or Injury;</li> <li>3. Totally Disabled.]]</li> </ol>
<b>[Age</b>	<p>A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. {Thereafter, it is his Age attained on: [the last Policy anniversary;] or [his last birthday.]}]</p>
<b>[Aircraft</b>	<p>A vehicle which:</p> <ol style="list-style-type: none"> <li>1. has a valid certificate of airworthiness; and</li> <li>2. is being flown by a pilot with a valid license to operate the Aircraft.]]</li> </ol>
<b>[Certificate</b>	<p>The Certificate is not the Policy and is evidence of the Employee/Member's coverage under the Policy. Coverage is subject to the Policy provisions.]]</p>
<b>Complications of Pregnancy</b>	<p>Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; but does not include false labor; pre-term or premature labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning Sickness; hyperemesis gravidarum; pre-eclampsia; and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Also included is: a non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy; occurring during a period of gestation in which a viable birth is not possible.</p>
<b>[Core Plan</b>	<p>The noncontributory plan of benefits provided under this Policy.]]</p>
<b>Covered Accident</b>	<p>A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:</p>

	<ol style="list-style-type: none"> <li>1. occurs while the Covered Person is insured under this Policy;</li> <li>2. is not contributed to by disease, Sickness, mental or bodily infirmity;</li> <li>3. [occurs while the Covered Person is { attending}{, participating in,} {or traveling to and from} any event sponsored by the Policyholder;</li> <li>4. is not otherwise excluded under the terms of this Policy.</li> </ol>
<b>[Covered Injury]</b>	Any bodily harm that results directly and independently of all other causes from a Covered Accident.]
<b>[Covered Loss]</b>	<p>A loss that is all of the following:</p> <ol style="list-style-type: none"> <li>1. the result, directly and independently of all other causes, of a Covered Accident;</li> <li>2. one of the Covered Losses specified in the Schedule of Covered Losses;</li> <li>3. suffered by the Covered Person within the applicable time period specified in the <i>Schedule of Benefits</i>.]</li> </ol>
<b>Covered Person</b>	An eligible person, as defined in the Schedule of Benefits, for whom [an enrollment form has been accepted by Us and] required premium has been paid when due and for whom coverage under this Policy remains in force. [The term Covered Person shall include, where this Policy provides coverage, an eligible Spouse and eligible Dependent Children.]
<b>[Dependent Child(ren)]</b>	<p>An [Employee's] [Member's] unmarried child who meets the following requirements:</p> <ol style="list-style-type: none"> <li>1. A child from live birth to {19} years old;</li> <li>2. A child who is {19} or more years old but less than {23} years old, enrolled in a school [as a full-time student] and primarily supported by the [Employee] [Member];</li> <li>3. A child who is {19} or more years old, chiefly dependent on the [Employee] [Member] for support and maintenance and incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapable prior to his 19<sup>th</sup> birthday. Notice of the child's condition and dependence must be submitted to Us. If the incapacity or dependency is later removed or terminated, the [Employee] [Member] must notify Us of the change. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.</li> </ol> <p>A child, for purposes of this provision, includes an [Employee's] [Member's]:</p> <ol style="list-style-type: none"> <li>1. natural child;</li> <li>2. child under the charge, care, and control of the [Employee] [Member] whom the [Employee] [Member] has filed a petition to adopt, until the dismissal or denial of the petition for adoption;</li> <li>3. stepchild [who resides with the [Employee] [Member]], [unless group term life insurance is provided by a non-custodial parent pursuant to a Qualified Domestic Relations Order];</li> <li>4. [child for whom the [Employee] [Member] is legal guardian.]</li> </ol> <p>[If an [Employee] [Member] who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with the [Employee] [Member] for at least [six consecutive months] and intend to reside with the [Employee] [Member] for an indefinite period of time.]]</p>

<b>[Domestic Partners]</b>	<p>A person of the same or opposite sex who:</p> <ol style="list-style-type: none"> <li>1. shares the covered [Employee's] [Member's] permanent residence;</li> <li>2. has resided with the covered [Employee] [Member] continuously for at least {six months - two years} and is expected to reside with the covered [Employee] [Member] indefinitely;</li> <li>3. Is financially interdependent with the covered [Employee] [Member] in each of the following ways: <ol style="list-style-type: none"> <li>[a. by holding one or more credit or bank accounts, including a checking account, as joint owners;]</li> <li>[b. by owning or leasing their permanent residence as joint tenants;]</li> <li>[c. by naming, or being named by, the covered [Employee] [Member] as a beneficiary of life insurance or under a will;]</li> <li>[d. by each agreeing in writing to assume financial responsibility for the welfare of the other;]</li> </ol> </li> <li>4. has signed a Domestic Partner declaration with the covered [Employee] [Member], if the covered [Employee] [Member] resides in a jurisdiction which provides for a Domestic Partner declaration;]</li> <li>5. has not signed a Domestic Partner declaration with any other person within the last {12 - 24 months;}</li> <li>6. is no less than {18 - 23} years not more than {60 - 70} years of age;</li> <li>7. is not legally permitted to marry the covered [Employee] [Member];]</li> <li>8. is not legally married to any other person;</li> <li>9. is not a blood relative any closer than would prohibit legal marriage.</li> </ol> <p>[In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.]</p> <p>A covered [Employee] [Member] may insure a Domestic Partner if all of the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. the covered [Employee] [Member] has not been married to any person within the past {12 - 24} months;</li> <li>2. the Domestic Partner is the only person meeting this Policy's definition of "Domestic Partner" with respect to the covered [Employee] [Member];</li> <li>3. The covered [Employee] [Member] and the Domestic Partner furnish a notarized affidavit/signed statement reflecting these requirements, and an agreement to notify Us if the requirements cease to be met, on a form acceptable to Us.]]</li> </ol>
<b>[Effective Date]</b>	The date on which insurance under the Policy begins as shown in the Schedule of Benefits.]]
<b>[Emergency Room Treatment]</b>	Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition of such nature that failure to render immediate care could reasonably result in deterioration to the point of placing a Covered Person's life in jeopardy or cause serious impairment to bodily functions.]]
<b>[Employee]</b>	For eligibility purposes, an Employee of the Policyholder who is in one of the Covered Classes. [The term does not include Employees who work less than {20 - 30 hours per week} for the Policyholder.]]
<b>[Employer]</b>	The Policyholder and any affiliates, subsidiaries or divisions shown in the <i>Schedule of Covered Affiliates</i> and which are covered under this Policy on the date of issue or subsequently agreed to by Us.]]

<b>[He, His, Him</b>	Refers to any individual, male or female.]
<b>[Hospital</b>	<p>An institution that meets all of the following:</p> <ol style="list-style-type: none"> <li>1. it is licensed as a Hospital pursuant to applicable law;</li> <li>2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;</li> <li>3. it is managed under the supervision of a staff of medical doctors;</li> <li>4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);</li> <li>5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;</li> <li>6. it charges for its services.</li> </ol> <p>[Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.]</p> <p>The term Hospital does not include a clinic, facility, or unit of a Hospital for:</p> <ol style="list-style-type: none"> <li>1. rehabilitation, convalescent, custodial, educational or nursing care;</li> <li>2. the aged, drug addicts or alcoholics;</li> <li>3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.]]</li> </ol>
<b>[Hospital Stay</b>	A confinement in a Hospital, ordered by a Physician, over a period of time when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least { 90 days - 180 days}.
<b>[Inpatient</b>	A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.]
<b>[Insured</b>	A person: (1) who is a member of an eligible class of person as described in the Schedule of Benefits; (2) for whom premium has been paid; and (3) while covered under this Policy.]
<b>[Member</b>	<p>For eligibility purposes, a Member is any one of the following:</p> <ol style="list-style-type: none"> <li>[1. an Employee of the Policyholder, [not including a temporary or seasonal Employee];]</li> <li>[2. an Employee of a Member in good standing of a Policyholder [, not including a temporary or seasonal employee]];</li> <li>[3. a person who meets all of the conditions of membership of a Policyholder];</li> </ol> <p>[and who is [Optional, a United States citizen or has a permanent alien registration card and who is] in one of the Covered Classes.]]</p>
<b>[Nurse</b>	<p>A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not:</p> <ol style="list-style-type: none"> <li>1. employed or retained by the Policyholder;</li> <li>2. living in the Covered Person's household; or</li> <li>3. a parent, sibling, spouse or child of the Covered Person.]</li> </ol>

<b>[Outpatient</b>	A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.]
<b>[Physical Therapist</b>	Any practitioner of physical therapy who is duly licensed in the state where he is practicing and who is practicing within the scope and limitations of that license.]
<b>[Physician</b>	A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: 1. employed or retained by the Policyholder; 2. living in the Covered Person's household; 3. a parent, sibling, spouse or child of the Covered Person.]
<b>[Permanent Total Disability</b>	[An Employee][A Member][A Spouse] who is Totally Disabled and is expected to remain Totally Disabled, as certified by a Physician, for the rest of his life.
<b>[Policy</b>	A legal contract between the Policyholder and the Company which describes the terms and conditions of insurance subject to its provisions, limitations and exclusions.]
<b>[Prior Plan</b>	The plan of insurance, {former plan number, former insurance company name} providing similar benefits, sponsored by the Policyholder in effect immediately prior to this Policy's Effective Date.]
<b>[Rehabilitation Facility</b>	A legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which: 1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation Inpatient care; 2. is duly licensed by the appropriate government agency to provide such services; and 3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission of Accreditation of Rehabilitation Facilities.  A Rehabilitation Facility does not include institutions which provide only: minimal care; custodial care; care for the terminally ill; part-time care; or services or facilities for drug abuse or alcoholism.]
<b>[Related Stays</b>	Successive stays in a Hospital unless: 1. any stay after the first is necessitated by causes entirely unrelated to the causes of the earlier stay; or 2. the stays are separated by at least {180 days}.]
<b>[Schedule of Benefits</b>	A brief outline of the coverage and benefits provided by this Policy.]
<b>[Sickness</b>	A physical or mental illness [including pregnancy]. Complications of pregnancy are considered a Sickness.]
<b>[Spouse[*</b>  *The term Spouse includes a Domestic Partner as defined.]	The [Employee's] [Member's] lawful spouse [who is aged {18 – under age 70.} [who is a United States citizen or has a permanent Alien Registration Card.] [Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed by {or divorced or legally separated from} an [Employee] [Member].]]

<b>[Termination Date]</b>	The date on which insurance ends as defined later in this Policy.]
<b>[Terrorism or Terrorist Act]</b>	<p>[Any hostile or violent act carried out by a group of persons having political or military goals but not operating on behalf of a foreign state and whose purpose is to compel an act or omission by any other person or governmental entity.]</p> <p><i>or</i></p> <p><b>[Domestic Terrorism</b> means the unlawful use, or threatened use, of force or violence, by a group or individual based and operating entirely within the United States or Puerto Rico without foreign direction, committed against persons or property to intimidate or coerce: a government; the civilian population; or any segment thereof; in furtherance of political or social objectives.</p> <p><b>International Terrorism</b> means violent acts or acts dangerous to human life occurring inside or outside of the United States: that are a violation of the criminal laws of the United States or any state; or that would be a criminal violation if committed within the jurisdiction of the United States or any state. The acts are committed to: intimidate or coerce a civilian population; influence the policy of a government by intimidation or coercion; or affect the conduct of a government by assassination or kidnapping.</p> <p><b>International Terrorist Group</b> means any group: practicing; or that has significant subgroups that practice; international terrorism that has been designated as a foreign terrorist organization by the United States Department of State.]]</p>
<b>[Totally Disabled or Total Disability]</b>	<p>Totally Disabled or Total Disability means [either]:</p> <ol style="list-style-type: none"> <li>1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of: education; training; or experience; [or]</li> <li>2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including: eating; transferring; dressing; toileting; bathing; and continence; without human supervision or assistance.]</li> </ol>
<b>[We, Us, Our]</b>	Catlin Insurance Company, Inc.]

## **ELIGIBILITY AND EFFECTIVE DATE PROVISIONS**

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### **[Policy Effective Date**

The Insurance Company agrees to provide Accident Insurance Benefits described in this Policy in consideration of: the Policyholder's application; and payment of the initial premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page [as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied].]

### **Eligibility**

[An Employee] [A Member] becomes eligible for insurance under this Policy on the date: he meets all of the requirements of one of the Covered Classes; and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* [and is insured under the Core Plan]. [A Spouse and Dependent Children of an eligible [Employee] [Member] become eligible for any dependent insurance provided by this Policy on the later of: the date the [Employee] [Member] becomes eligible; and the date the Spouse or Dependent Child meets the applicable definition shown in the *Definitions* section of this Policy.] [No person may be eligible for insurance under this Policy as both [an Employee] [a Member] and a Spouse or Dependent Child at the same time.]

[An Employee] [A Member] whose eligible class is changed after the Effective Date of his coverage shall become eligible under the new eligible class on the [first day of the month coinciding with or next following] the date of the change.

[The [Employee] [Member] Eligibility Waiting Period may differ for current and newly covered persons. ]

### **[Effective Date for Individuals**

Insurance becomes effective for an eligible [Employee] [Member] [who applies: within {31 days} of the date he becomes eligible; [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under this Policy;
2. [the date][the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date][the first of the month after] We receive the [Employee's] [Member's] completed enrollment form during his lifetime.]

[We may, from time to time, require the [Employee] [Member] to re-enroll using forms supplied by Us to keep his insurance in force.}]

[Insurance becomes effective for an [Employee's] [Member's] eligible Dependent Children [if the [Employee] [Member] applies: within {31 days} of the date his Dependent Children become eligible;] [and, subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of Policyholder under this Policy;
2. [the date][the first of the month after] the [Employee] [Member] becomes eligible;]
3. [the date][the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
4. [the date] [the first of the month after] the Spouse or Dependent Child meets the definition of Spouse or Dependent Child, as applicable;]
5. [the date] [the first of the month after] We receive the [Employee's] [Member's] completed enrollment form for Spouse and Dependent Child coverage, during each Spouse or Dependent Child's lifetime.]

[Insurance becomes effective for an eligible [Employee] [Member] who applies and agrees to make required contributions: within {31 days} of eligibility;] [and subject to the *Deferred Effective Date* provision below,] on the latest of the following dates:

1. the effective date of the Policyholder under this Policy;
2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;
3. [the date] [the first of the month after] We receive the [Employee's] [Member's] completed enrollment form and the required first premium, during his lifetime.]]

[Insurance becomes effective for an [Employee's] [Member's] eligible Dependent Children if the [Employee] [Member] applies and agrees to make required contributions within {31 days} of the date his Dependent Children become eligible [and, subject to the *Deferred Effective Date* provision below], on the latest of the following dates:

1. the effective date of Policyholder under this Policy;
2. [the date] [the first of the month after] the [Employee] [Member] becomes eligible;]
3. [the date] [the first of the month after] the [Employee's] [Member's] insurance becomes effective;]
- 4.] [the date] [the first of the month after] the Spouse or Dependent Child meets the definition of Spouse or Dependent Child, as applicable;
- 5.] [the date] [the first of the month after] We receive a completed enrollment form for Spouse and Dependent Child coverage and the required first premium, during each Dependent Child's lifetime.]

**Newborn Children:** [An Employee's] [A Member's] newborn child is automatically covered from the moment of birth until such child is 90 days old if all other eligible children are covered under the certificate prior to the birth of the newborn child. Coverage for newborns shall be the same as for all other covered Dependent Children. The [Employee] [Member] must notify the Company in writing within 90 days of such birth or before the next premium due date, whichever is later, and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

**Adopted Children:** An adopted child is automatically covered for the first 60 days from the date of the [Employee] [Member] filing a petition for adoption unless the petition is denied or dismissed. Coverage for such child will be the same as for all other covered Dependent Children. The [Employee] [Member] must: notify the Company in writing within 60 days of: filing the petition for adoption; and pay the required additional premium (if any); in order to have coverage for the adopted child continue beyond such 60 day period.

#### **[DEFERRED EFFECTIVE DATE**

##### **[Active Service**

The effective date of insurance will be deferred for any [Employee] [Member] [or any eligible Spouse or Dependent Child] who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of: the date he returns to Active Service; and the date coverage would otherwise have become effective.]

##### **[Late Enrollment**

If application for insurance is not made within {31 days} of the date a person is first eligible for coverage [or a Life Status Change] [or during an Annual Re-Enrollment], the Covered Person will be considered a late enrollee. Coverage for any late enrollee will become effective on the later of: the date We approve the required evidence of insurability and receive required premium; and the date coverage would otherwise have become effective.]

##### **[Replacement Coverage**

[An Employee] [A Member] [and any Spouse and Dependent Children] who were insured under a Prior Plan and who is a member of the class of individuals eligible for coverage under this Policy on the effective date of the Policyholder under this Policy will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; and
2. the amount of coverage provided under this Policy.

If the amount of coverage otherwise provided by this Policy is greater than the amount provided under the Prior Plan, the greater amount will become effective on the {first day of the month on or after, or first day of the Policy year on or after or date] the [Employee] [Member], [Spouse or Dependent Child] returns to Active Service.]

[If [an Employee] [a Member] is required to contribute to the cost of any portion of his [or his Dependent Children's] insurance and is not in Active Service on the effective date of the Policyholder under this Policy, coverage will terminate {31 days} after the [Employee] [Member] returns to Active Service unless he submits an enrollment form and the required initial premium. If the [Employee] [Member] selects the amount of benefit for which he is required to pay premium for himself [or any Dependent Children], the amount in effect under this provision will be the lesser of: the amount provided under the Prior Plan; and the smallest amount he may select under this Policy.]

### **[Annual Re-Enrollment**

[An Employee] [A Member] currently insured under {the voluntary Accident portion of} this Policy, and a person who is eligible but has not previously enrolled, may increase or become insured for coverage under this Policy during an annual re-enrollment period as agreed to by Us and the Policyholder. [An Employee] [A Member] who is insured under this Policy may also elect or increase coverage for his eligible Dependent Children.] Coverage elected during an Annual Re-Enrollment Period will become effective [, subject to the *Active Service* section of the *Deferred Effective Date* provision,] on [the Policy Anniversary following, or first day of the month following the] date We receive a request and any required premium payment.]

### **[Life Status Change**

A Life Status Change an event that the Policyholder determines qualifies [an Employee] [a Member] to [elect,] or increase accident insurance benefits [for himself and his Spouse and Dependent Children]. [Any change in benefit elections must be made within {31 days} of a Life Status Change.]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase his accident insurance include:

- [1. marriage];
- [2. loss of a spouse, whether by death, divorce, annulment or legal separation];
- [3. birth or adoption of a child, or acquiring a child through marriage]; and
- [4. an increase in cost or a significant reduction or loss of group accident benefits provided by a Spouse's Plan].]

[Life Status Changes that qualify [an Employee] [a Member] to [elect or] increase accident insurance for his Spouse and eligible Dependent Children include:

- [1. marriage];
- [2. birth or adoption of a child, or acquiring a child through marriage]; and
- [3. a significant reduction, increase in cost or loss of group accident benefits provided by a Spouse's Plan].]

Any increases in benefits or added benefits elected under this Life Status Change provision will become effective on the [{first of the month following the} Life Status Change *or* the {first day of the month following the} date the [Employee] [Member] applies and agrees to make required contributions]].

[The Policyholder should seek advice of its tax advisors if [Employees] [Members] may contribute to the cost of any insurance provided by this Policy with earnings not subject to Federal Income Tax. We cannot provide such advice nor offer any opinions on taxation or tax status of any contributions toward cost of insurance.]]

### **Effective Date of Changes**

Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the [Employee's] [Member's] Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

### **TERMINATION OF INSURANCE**

The insurance on a Covered Person will end on the earliest date below:

1. the date this Policy or insurance for a Covered Class is terminated;
- [2. the date the Policyholder's coverage under this Policy ends;]
3. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
4. the last day of the last period for which premium is paid;
- [5. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy, as shown in the *Schedule of Benefits*;]
- [6. with respect to a Spouse {or Dependent Child}, the date of the death of the covered [Employee] [Member] [or the date of divorce from the covered [Employee] [Member], unless the Spouse elects to continue insurance, including insurance on Dependent Children.] See *Continuation of Insurance* section;]
- [7. the date that the plan of benefits under which the Covered Person is covered is terminated.]

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

#### **[CONTINUATION OF INSURANCE**

Insurance for the covered Spouse [and Dependent Children] may be continued if a covered Spouse's [and Dependent Children's] insurance would otherwise end because of death of or divorce from the covered [Employee] [Member]. The Covered Spouse must:

1. submit a written request for continued insurance to Us within {31, 60, 90 days} of the event; and
2. pay the required premium to the Policyholder directly to Us.]

[Insurance continued under this provision may not exceed the amount of insurance in force on the day before insurance as a covered Spouse ended, nor may a Spouse add any Dependent Children for insurance.]

Premiums for insurance continued under this provision will start with: the Premium Due Date on; or next following the date of the event. If a Spouse does not: elect to continue insurance under this provision; or does not provide notification within the required time period; insurance will not be continued and any premium paid from the date of the event will be refunded. [However, if notification is not given to Us within the time period required in (1.) above, any return of premium will be limited to any excess paid in the last {six, 12 months}]

Any Continuation of Insurance is subject to Our continuing to offer insurance under this Policy to new applicants.]

#### **[CONTINUATION OF INSURANCE**

We will continue insurance under this Policy for a Spouse [and Dependent Children] of a covered [Employee] [Member] who dies, without payment of premium for {12 to 24 months}. The Spouse [and Dependent Children]: (a) must have been insured under this Policy on the date the [Employee] [Member] died; and (b) must continue to meet all other requirements for eligibility. Coverage continued under this provision will terminate on the earlier of: the end of {the 12<sup>th</sup> month}; and the date the Spouse [or any Dependent Child] ceases to meet all other requirements for eligibility.

#### **[Continuation for {Layoff, Leave of Absence or Family Medical Leave}**

Insurance for [an Employee] [a Member] {and covered Dependent Children} may be continued until the earliest of the following dates if: (a) [an Employee] [a Member] is on a temporary {layoff, an approved leave of absence or an approved family medical leave}; and (b) required premium contributions are paid when due.

1. [for a layoff, [{six months} after] the end of the month in which the layoff begins;]
2. [for an approved leave of absence: [{six months after] the end of the month in which the leave begins;]
3. [for an approved family medical leave {12 weeks in a consecutive 12-month period.}]

[Such continuation will {run concurrently with, precede} a continuation during any other leave.]]

#### **[Continuation for Military Service**

If [an Employee] [a Member] begins a leave of absence to serve in the armed forces, insurance for the [Employee] [Member] {and his Covered Dependent Children} will continue until the earliest of the following dates, if the required premium is paid:

1. 18 months;
2. the day the [Employee] [Member] fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when coverage is continued under this provision:

1. [any change in benefits that occurs during the period of continuation will apply on the effective date of the change;]
2. [any Active Service requirement will be waived; ]
3. The [Employee] [Member] will be given credit for the time he was covered under this Policy prior to the leave.

If [an Employee] [a Member] does not continue coverage for himself [and his Dependent Children] during such leave and returns to [work] [membership]:

1. the [Employee] [Member] [and his Dependent Children] will be covered on the date the [Employee] [Member] returns to [work] [membership] from the leave. The [Employee] [Member] must return to [work] [membership] as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;

2. any portion of an eligibility waiting period that has not been completed will not be credited during the [Employee's] [Member's] leave.]]

## COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

- [1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane];
- [2. commission or attempt to commit a felony or an assault];
- [3. commission of or active participation in: a riot; insurrection; or Terrorist Act];
- [4. {bungee jumping;}{ parachuting;}{ skydiving;}{ parasailing;}{ hang-gliding}];
- [5. declared or undeclared war or act of war];
- [6. Terrorism [or Terrorist Acts]];
- [7. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as:
  - a. a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - b. a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
  - c. a passenger in a military Aircraft flown by the Air Mobility Command or its foreign equivalent;] or
- [8. flight in; boarding; or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
  - [a. except as a fare-paying passenger on a regularly scheduled commercial airline];
  - [b. being flown by the Covered Person or in which the Covered Person is a member of the crew];
  - [c. being used for:
    - [i. crop dusting; spraying or seeding; giving and receiving flying instruction; fire fighting; sky writing; sky diving or hang-gliding; pipeline or power line inspection; aerial photography or exploration; racing; endurance tests; stunt or acrobatic flying]; or
    - [ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);]
  - [d. designed for flight above or beyond the earth's atmosphere];
  - [e. an ultra-light or glider];
  - [f. being used for the purpose of parachuting or skydiving];
  - [g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;]
- [9. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle];
- [10. participation in any motorized race or contest of speed];
- [11. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program];
- [12. Sickness; disease; bodily or mental infirmity; bacterial or viral infection; or medical or surgical treatment thereof; except for any bacterial infection resulting from: an accidental external cut or wound; or accidental ingestion of contaminated food];
- [13. medical or surgical treatment; diagnostic procedure; administration of anesthesia; or medical mishap or negligence; including malpractice];
- [14. travel or activity outside the United States or Canada];
- [15. travel in any Aircraft: owned; leased; or controlled by the Policyholder; or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year];
- [16. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred];
- [17. voluntary ingestion of: any narcotic; drug; poison; gas or fumes; unless: prescribed or taken under the direction of a Physician; and taken in accordance with the prescribed dosage];
- [18. injuries compensable under: Workers' Compensation law; or any similar law];
- [19. occupational injuries for which benefits are not paid under: the Workers' Compensation Law; or any similar law];
- [20. injuries that result from a non-occupational accident];
- [21. a Covered Accident that occurs while on active duty service in: the military; naval; or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days];

In addition, benefits will not be paid for:

- [22. services or treatment rendered by: a Physician; Nurse; or any other person who is:
  - a. employed or retained by the Policyholder;
  - b. providing: homeopathic; aroma-therapeutic; or herbal therapeutic services;
  - c. living in the Covered Person's household;
  - d. who is: a parent; sibling; spouse; or child of the Covered Person];
- [23. any Hospital Stay or days of a Hospital Stay that are not appropriate for the condition and locality.]

## [CONVERSION PRIVILEGE]

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- [1. If the Covered Person's insurance or any portion of it ends for a reason other than: non-payment of premium; the Covered Person's Age; or those reasons described in Paragraph 2 below; the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated policy. The Covered Person may not apply for an amount greater than his coverage under this Policy [less the amount of any other group accident insurance for which he becomes eligible within 31 days after the date coverage under this Policy terminated.] The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

The Covered Person must apply for the individual policy within 31 days after his coverage under this Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk.

The individual policy or certificate will take effect on the day following the date coverage under the Policy ended. If the Covered Person dies during this 31-day period as the result of an accident that would have been covered under this Policy, We will pay as a claim under this Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Policy.

2. If the Covered Person's insurance ends because this Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Policy for at least five year's the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
  - a. coverage under this Policy less any amount of group accident insurance: for which he is eligible on the date this Policy is terminated; or for which he became eligible within 31 days of such termination; or
  - b. {\$10,000}]

## **CLAIM PROVISIONS**

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### **Notice of Claim**

Written {or authorized electronic/telephonic} notice of claim must be given to Us: within {31 days} after a Covered Loss occurs or begins; or as soon as reasonably possible. If written {or authorized electronic/telephonic} notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written {or authorized electronic/telephonic} notice was given as soon as was reasonably possible. Notice can be given to Us: at Our Home Office in Houston, Texas; or such other place as We may designate for the purpose; or to Our authorized agent. Notice should include: the Policyholder's name and policy number; and the Covered Person's name; address; policy; and certificate number.

### **Claim Forms**

We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written {or authorized electronic} proof of the nature and extent of the loss for which the claim is made.

### **[Claimant Cooperation Provision**

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

### **Proof of Loss**

Written {or authorized electronic} proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss; then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written {or authorized electronic} notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written {or authorized electronic} proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

[The Plan Administrator of the Policyholder's employee welfare benefit plan (the Plan) has selected the Insurance Company as the Plan fiduciary under federal law for the review of claims for benefits provided by this Policy and for deciding appeals of denied claims. In this role the Insurance Company shall have the authority, in its discretion: to interpret the terms of the Plan documents; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by the Insurance Company in this capacity shall be final and binding on Participants and Beneficiaries of The Plan to the full extent permitted by law.

The Insurance Company has no fiduciary responsibility with respect to the administration of The Plan except as described above. It is understood that the Insurance Company's sole liability to the Plan and to Participants and Beneficiaries under The Plan shall be for the payment of benefits provided under this Policy.]

### **Time of Payment of Claims**

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written {or authorized electronic} proof of such loss. Subject to due written {or authorized electronic} proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid no later than at the expiration of each period of thirty (30) days during the continuance of the period for which We are liable unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

### **Payment of Claims**

All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered [Employee] [Member], his estate, or the hospital or person rendering services upon request by the group Policyholder.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay { \$1,000 - \$5,000} to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability, unless, before payment is made, We have received at Our home office written notice by or on behalf of another person that the other person claims to be entitled to the payment or some interest in the Policy.

#### **[Payment of Claims to Foreign [Employees] [Members]**

The Policyholder may, in a fiduciary capacity, receive and hold any benefits payable to covered [Employees] [Members] whose place of [employment] [membership] is other than:

- {1. the United States of America;}
- {2. Puerto Rico; or}
- {3. the Dominion of Canada}.

We will not be responsible for the application or disposition by the Policyholder of any such benefits paid. Our payments to the Policyholder will constitute a full discharge of Our liability for those payments under this Policy.]

#### **Physical Examination [and Autopsy]**

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

#### **Legal Actions**

No action at law or in equity may be brought to recover under this Policy less than 60 days after written {or authorized electronic} proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

#### **Beneficiary**

The beneficiary is the person or persons the [Employee] [Member] names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary [, or to make any assignment of rights or benefits permitted by this Policy.] [A separate beneficiary may be designated to receive any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child.] [Any Accidental Death Benefit payable at the death of the [Employee's] [Member's] Spouse or Dependent Child will be paid to the [Employee's] [Member's] estate.]

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the [Employee] [Member] has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the [Employee] [Member] dies while benefits are payable to him, We may make direct payment to [the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. mother or father;
4. sisters or brothers;
5. estate of the [Employee] [Member].]

Or

[the estate of the [Employee] [Member].]

#### **Recovery of Overpayment**

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount;
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

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## **ADMINISTRATIVE PROVISIONS**

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### **Premiums**

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. [If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day before the reduction took place.]

### **Changes in Premium Rates**

We may change the premium rates from time to time with at least {31 days} advance written notice to the Policyholder. No change in rates will be made until {12 months} after the Policy Effective Date. An increase in rates will not be made more often than once in {a 12-month period}. However, We reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
- [2. the terms of the Policyholder's participation change;]
- [3.] a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
- [4.] there is a change in the factors bearing on the risk assumed;
- [5.] any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

### **Payment of Premium**

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder.

If any premium is not paid on the Premium Due Date when due, this Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period section.

### **Grace Period**

- [1. {Policy}]

A Policy Grace Period of {31 days} will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force.]

- [2. Covered Person]

A Grace Period of {31 days} will be granted for payment of required premiums under this Policy. A Covered Person's insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the grace period by the amount of premium due. If: no such claims are incurred; and premium is not paid during the grace period; insurance will end on the last day of the period for which premiums were paid.]

## **GENERAL PROVISIONS**

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### **Entire Contract; Changes**

This Policy, including: the endorsements; amendments; and any attached papers; constitutes the entire contract of insurance. No change in this Policy will be valid until: approved by one of Our executive officers; and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

### **Misstatement of Fact**

If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

### **Certificates**

Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list: the benefits; conditions; and limits of this Policy. It will state to whom benefits will be paid.

### **Multiple Certificates**

The Covered Person may have in force only one certificate at a time under this Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.]

[A Covered Person is not eligible for insurance under more than {one certificate providing benefits for accident insurance under group policies issued by Us}. If premium is being paid for more than one such certificate, insurance will be in effect under the certificate with the earliest effective date and premiums paid for certificates which are not in effect will be refunded.]]

### **Assignment**

*Option 1: Include if no rights and benefits are assignable:*

[The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.]

*Option 2: Include when no assignment other than benefits that have become payable is permitted:*

[The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Accident. Any other attempt to assign will be void.]

*Option 3: Include if assignment is permissible:*

[We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while: the assignment remains in effect; and insurance under this Policy and the Covered Person's certificate remains in force. We will deal with the assignee as the owner or pledge of the Policy in accordance with the terms of the assignment until We have received at Our home office written notice of termination of the assignment or written notice by or on behalf of some other person claiming some interest in the Policy in conflict with the assignment.]

## **Incontestability**

### **1. Of This Policy or Participation Under This Policy**

All statements made by the Policyholder to obtain this Policy are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; or to deny the validity of this Policy or of participation under this Policy; unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

### **2. Of a Covered Person's Insurance**

All statements made by a Covered Person are considered representations and not warranties. No statement will be used: to deny or reduce benefits; or be used as a defense to a claim; unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from: the Covered Person's effective date of insurance; or from the effective date of increased benefits; no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

## **[Reporting Requirements**

The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. additional information required by Us.]

## **Policy Termination**

We may terminate coverage on or after [the first anniversary of the policy effective date]. The Policyholder may terminate coverage on any premium due date. Written {or authorized electronic} notice must be given at least {31 days} prior to such premium due date. [Failure by the Policyholder to pay premiums when due or within the grace period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

## **[Reinstatement**

This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are: written application of the Policyholder satisfactory to Us; and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid [, but not to any period more than {60 days} prior to the date of reinstatement.]]

## **Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

## **Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

## **Policy Changes**

We may agree with the Policyholder to modify a plan of benefits without the Covered Person's consent.

**Workers' Compensation Insurance**

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

**Examination of the Policy**

This Policy will be available for inspection at the Policyholder's office during regular business hours.

**Examination of Records**

We will be permitted to examine all of the Policyholder's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force; or it may occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all Policy claims.

The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

## DESCRIPTION OF [COVERAGES] AND BENEFITS

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This Description of [Coverages and] Benefits Section describes the Accident [Coverages and] Benefits provided by this Policy. Benefit amounts; benefit periods; and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits*. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand: all of the terms; conditions; and limitations applicable to these [coverages and] benefits.

### [ACCIDENTAL DEATH BENEFIT

- Covered Loss** We will pay the benefit shown in the *Schedule of Benefits* if a Covered Person dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].
- Exclusions** Exclusions that apply to this Benefit are specified in *Common Exclusions* Section.]

### [ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

- Covered Loss** We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident [within the applicable time period specified in the *Schedule of Benefits*].

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable.] If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

### Definitions

**[Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.]

**[Loss of Sight** means the total, permanent loss of all vision in one eye which is irrecoverable by: natural; surgical; or artificial means.]

**[Loss of Speech** means total and permanent loss of audible communication which is irrecoverable by: natural; surgical; or artificial means.]

**[Loss of Hearing** means total and permanent loss of ability to hear any sound {in both ears} which is irrecoverable by: natural; surgical; or artificial means.]

**[Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand** means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).]

**[Loss of Toes** means complete Severance through the

metatarsalphalangeal joint.]

**[Paralysis or Paralyzed** means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.]

**[Quadriplegia** means total Paralysis of both upper and both lower limbs.]

**[Hemiplegia** means total Paralysis of the upper and lower limbs on one side of the body.]

**[Paraplegia** means total Paralysis of both lower limbs or both upper limbs.]

**[Uniplegia** means total Paralysis of one upper or one lower limb.]

**[Coma** means a profound state of unconsciousness: which resulted directly and independently from all other causes from a Covered Accident; and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.]

**[Severance** means the complete and permanent separation and dismemberment of the part from the body.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[ADDITIONAL [ACCIDENTAL DEATH AND DISMEMBERMENT] COVERAGES]**

[{Accidental Death and Dismemberment} benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other {Accidental Death and Dismemberment} benefits payable.]

#### **[ARMED FORCES COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while he is on active duty in any Armed Forces.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

#### **[EXPOSURE AND DISAPPEARANCE COVERAGE]**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within {1 – 7 years} from the date of: the wrecking; sinking; or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[NATIONAL GUARD AND ARMED FORCES RESERVE COVERAGE**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable subject to the following conditions if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while the Covered Person is a member of the U.S. Military Reserve or National Guard.

While the Covered Person is a member of the U.S. Military Reserve or National Guard, coverage under this Policy will remain in force beyond the 31-day active duty training period and continue:

1. during the Covered Person's initial training period;
2. if the Covered Person is called to active duty [for a domestic emergency].

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[OWNED AIRCRAFT COVERAGE**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs: during travel or flight in; including getting in or out of; any Aircraft that is: owned; leased; operated; or controlled by the Policyholder (or any of its subsidiaries or affiliates). A record of eligible Aircraft will be maintained by the Policyholder and available for review by Us at any time during normal business hours. An Aircraft substituted for an eligible Aircraft will also be eligible if it has no greater seating capacity and the original Aircraft is withdrawn from normal use due to: breakdown; repair; servicing; loss; or destruction.

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[PILOT COVERAGE**

Benefits for {Accidental Death and Dismemberment}, as shown in the *Schedule of Covered Losses*, will be payable if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs while: the Covered Person is flying as a licensed pilot [or member of the crew] of an Aircraft; and meets all of the following requirements:

- [1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by Us;]
- [2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by Us;]
- [3. completes and maintains a combined minimum of {200 hours} of military, private or professional logged flight hours;]
- [4. is flying as a pilot [or member of the crew] of an Aircraft traveling on or transacting business for the Policyholder. All trips must have been authorized in advance by the Policyholder;]
- [5. is flying as a pilot [or member of the crew] of an Aircraft [described below] or [on a list of eligible Aircraft maintained by the Policyholder, including a substitute Aircraft with no greater seating capacity while a [specified] or [listed] Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction;]
- [6. is flying as a pilot [or member of the crew] of an Aircraft that is [not] owned, leased, operated or controlled by the Policyholder;]
- [7. is not giving or receiving flight instruction.]

**[Description of Aircraft Covered** {XXXXXXXX will list: type of Aircraft; license number; and passenger seating capacity: Boeing 727; License # PA12345; passenger seating capacity: 45}]

**Exclusions** The exclusions that apply to this coverage are in the *Common Exclusions* Section.]

## **[WAR RISK COVERAGE**

Benefits for {Accidental Death and Dismemberment} as shown in the *Schedule of Covered Losses*, will be payable, subject to the following conditions and exclusions, if a Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during war or acts of war that occur in:

- {1. any specifically described geographic area such as Saudi Arabia, Iran, Serbia}; or
- {2. a generally described geographic area such as worldwide, excluding the United States and its territories and possessions.}

The Policyholder may cancel this war risk coverage at any time by sending written notice to Us at Our home office address. Coverage will be canceled upon receipt of notice or a date specified by the Policyholder.

We may cancel this coverage at any time by providing written notice to the Policyholder at least {10 days} prior to termination of this coverage. Any unearned premium will be promptly returned to the Policyholder.

**Exclusions** This benefit does not provide coverage when a Covered Loss occurs:  
[1. in the United States and its territories and possessions; or]  
[2. in any nation of which the Covered Person is a citizen.]

{[Other} exclusions that apply to this coverage are in the *Common Exclusions* Section.]}

#### **[ADDITIONAL ACCIDENT BENEFITS]**

{[Accidental Death and Dismemberment benefits} are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other {Accidental Death and Dismemberment benefit} payable.]

#### **[ADDITIONAL OCCUPATIONAL BENEFIT]**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss which results directly and independently of all other causes from a Covered Accident that occurs while the covered [Employee] [Member] is on the Policyholder's premises and engaged in the course of his [job] [membership] [or on business travel pre-authorized by the Policyholder].

[Business travel begins at the actual start of a business trip that has been pre-authorized by the Policyholder, whether the trip starts at the covered [Employee's] [Member's]: home; place of work; or another place. Business travel coverage:

1. ends when the covered [Employee] [Member] arrives at his: home; or place of work; whichever happens first; and
2. is not in effect during the covered [Employee's] [Member's] Personal Deviation.]

[Business travel includes: riding in; or getting on or off of; an Aircraft, but only if:

1. the covered [Employee] [Member] is riding as a passenger only, and not as a pilot or member of the crew; and
2. the Aircraft is not being used for any of the following:
  - a. crop dusting, spraying or seeding;
  - b. fire fighting;
  - c. sky writing;
  - d. sky diving or hang gliding;
  - e. pipeline or power line inspection;
  - f. aerial photography or exploration;
  - g. racing;
  - h. endurance tests, stunt or acrobatic flying;
  - i. any operation which requires a special permit from the FAA, even if it is granted unless the permit is required only because of the territory flown over or landed on;
  - j. giving or receiving flying instruction.]

**Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs: prior to the end of the trip; [or within {one hour } before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]

**Exclusions** [Business travel coverage is not provided during:

1. normal commuting between the covered [Employee's] [Member's] home and place of work; or
2. the covered [Employee's] [Member's] Personal Deviation {in excess of 30 days}.

[[Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BEREAVEMENT AND TRAUMA COUNSELING BENEFIT**

We will pay counseling sessions, up to the Maximum Benefit Amount shown in the *Schedule of Benefits* and subject to the following conditions and exclusions, when the Covered Person {and/or Immediate Family Member} requires bereavement and trauma counseling because the Covered Person suffered a Covered Loss that resulted directly and independently of all other causes from a Covered Accident. Such counseling must meet all of the following conditions:

1. covered bereavement and trauma counseling expenses must be incurred within {one year} from [the date of the Covered Accident causing the Covered Loss];
2. the expense is charged for a bereavement or trauma counseling session for the Covered Person {and/or one or more of his Immediate Family Members};
3. counseling is provided under the care, supervision or order of a Physician;
4. a charge would have been made if no insurance existed.

**Definitions** For purposes of this benefit:

**Immediate Family Member** means a person who is related to the Covered Person in any of the following ways: Spouse; brother-in-law; sister-in-law; son-in-law; daughter-in-law; mother-in-law; father-in-law; parent (includes stepparent); brother or sister (includes stepbrother or stepsister); or child (includes legally adopted child or stepchild).

**Exclusions** Covered bereavement and trauma counseling benefits do not include any expense for which the Covered Person is entitled to benefits under any Workers' Compensation Act or similar law.

[[Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[BOMB SCARE, BOMB SEARCH OR BOMB EXPLOSION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. the covered [Employee] [Member] is on the Policyholder's premises when the Covered Accident occurs;
2. the Covered Accident is caused by or results from a Bomb Scare, Search or Explosion, as defined below;
3. the covered [Employee] [Member] is an authorized participant of a team or squad engaged in a Bomb Search or related activity;
4. the Policyholder authorizes the covered [Employee's] [Member's] participation and sanctions the search.

**Definitions** For purposes of this benefit:

**Bomb** means any real or dummy explosive device placed with intent to: damage; scare; or cause injury.

**Scare** means any real or false report of a Bomb on the premises of the Policyholder .

**Search** means any organized search for a reported Bomb.

**Explosion** means any detonation of a Bomb on the Policyholder's premises which appears to have been intended to cause injury or unlawful property damage, whether or not the presence of the Bomb was reported before detonation. [It does not include: any act of declared or undeclared war in the United States of America or Canada; or acceptance of known explosives as cargo.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section. ]

#### **[BULLETPROOF VEST BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the covered [Employee] [Member] {who is Age 18 or older} is on official duty for the Policyholder and is shot during a Covered Accident while wearing a Bulletproof Vest and:

1. the Bulletproof Vest fails to prevent the bullet's penetration through the vest; and
2. such penetration results, directly and independently of all other causes, in {a Covered Loss, Covered Injury}.

**Definition** For purposes of this benefit:

**Bulletproof Vest** means a protective vest designated as {Threat Level II-A; Threat Level II; or Threat Level III-A} [manufactured by a vendor designated by the Policyholder] and [purchased not more than {five years} before the Covered Accident.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[BURIAL AND CREMATION BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, for burial or cremation of the covered [Employee] [Member] who dies from a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[BUSINESS TRAVEL BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the covered [Employee] [Member] suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a business trip authorized in advance by the Policyholder. The Covered Loss must be sustained:

1. in the course of the covered [Employee's] [Member's] [job] [membership];
2. away from the premises of the Policyholder in the covered [Employee's] [Member's] city of permanent assignment].

Coverage will begin at the actual start of a business trip authorized by the Policyholder. It does not matter if the trip starts at the covered [Employee's] [Member's]: home; place of work; or any other place. Coverage will end when the covered [Employee] [Member] arrives at his: home; or place of work; whichever happens first.

**Definitions** For purposes of this benefit:

**Personal Deviation** means an activity that meets all of the following conditions:

1. is not reasonably related to the Policyholder's business trip;
2. is not incidental to the Policyholder's business;
3. occurs prior to the end of the trip [or within {one hour} before or after the trip].

[A Personal Deviation does not include extension of a business trip authorized in advance by the Policyholder as necessary to reduce transportation costs.]]

- Exclusions** Coverage for business travel is not provided during [any of the following]:
1. normal commuting between the covered [Employee's] [Member's] home and place of work;
  - [2. travel in an Aircraft: owned; leased; operated; or controlled by the Policyholder;]
  3. travel to another location where the [Employee] [Member] is expected to be assigned for more than {60 days} by the Policyholder;
  4. a covered [Employee's] [Member's] Personal Deviation [in excess of {31 days}].

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[CHILD CARE CENTER BENEFIT**

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered [Employee] [Member][Spouse] results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. coverage for his Dependent Children was in force on the date of the Covered Accident causing his death: and
2. one or more surviving Dependent Children is under Age {13}; and
  - [a. was enrolled in a Child Care Center on the date of the Covered Accident; or]
  - [b. enrolls in a Child Care Center within { 90 - 365 days} from the date of the Covered Accident].

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each {12 month} period that begins after the date of the covered [Employee's] [Member's][Spouse's] death. A claim must be submitted to Us at the end of each {12 month} period [with proof of enrollment and attendance]. A {12 month} period begins:

- [1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (2b) above, after the covered [Employee's] [Member's][Spouse's] death; or]
2. on the first of the month following the covered [Employee's] [Member's][Spouse's] death, if the Dependent Child was enrolled in a Child Care Center before the covered [Employee's] [Member's][Spouse's] death.

Each succeeding {12 month} period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

**Definitions** For purposes of this benefit:

**Child Care Center** is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

**[Surviving Spouse** will include the covered [Employee] [Member] and covered Spouse.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[COMMON CARRIER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:  
**Common Carrier** means:  
1. a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or  
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or a similar air transport service of another country.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[EMERGENCY ROOM BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, if a Covered Person requires Emergency Room Treatment due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

**Definition** For purposes of this benefit:  
**Emergency Room** means a trauma center or a special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Physician's office.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[ESCALATOR BENEFIT**

We will increase the Covered Person's Principal Sum by {the dollar amount or the percentage of Principal Sum} shown on the *Schedule of Benefits*, subject to the following conditions and exclusions. [The Covered Person must be under Age {55; 60} to be eligible for this benefit.] [Benefit amounts for {a covered Spouse, Dependent Child} will not be increased.]

[The Principal Sum used to calculate this benefit:

1. will be the amount in force when the Covered Person first becomes insured for this benefit;
2. will not compound previous Escalator benefit amounts.]

Increases will become effective on each {Policy or certificate anniversary} after the Covered Person has been insured for {12 consecutive months}. Benefit increases will occur automatically at the end of each {12 month} period, for a maximum of {five years}.

[Increases provided by this benefit will be calculated separately for each additional Principal Sum the Covered Person elects. The total amount of all increases will not exceed the highest amount shown in the *Schedule of Benefits*.

[If the Covered Person's Principal Sum is reduced, any increases provided under this benefit will be reduced in the same proportion.]

**Exclusions** [This benefit will not apply to any *Bonus Benefit*.]

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[FELONIOUS ASSAULT AND VIOLENT CRIME BENEFIT**

We will pay the amount shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and

independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault as described below. [A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid.] [The Covered Accident must occur while the Covered Person is on the business or premises of the Policyholder. ]

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

[We will pay a Hospital Stay Benefit, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

- [1. the Covered Person is covered for Hospital Stay benefits under this Policy;]
2. the Hospital Stay begins within {30 days} of the violent crime/felonious assault;
- [3. the Hospital Stay is at the direction and under the care of a Physician;]
4. the Covered Person provides proof satisfactory to Us that his Hospital Stay was necessitated to treat Covered Injuries sustained in a Covered Accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Definitions** For purposes of this benefit:

**Family Member** means the Covered Person's: parent; step-parent; Spouse or former Spouse; son; daughter; brother; sister; mother-in-law; father-in-law; son-in-law; daughter-in-law; brother-in-law; sister-in-law; aunt; uncle; cousins; grandparent; grandchild; and stepchild.

**Fellow [Employee] [Member]** means [a person employed by] [a member of] the same Entity as the Covered Person or by an Entity that is an affiliated or subsidiary entity. It shall also include any person who was so [employed] [qualified as a member], but whose [employment] [membership] was terminated not more than {45 days} prior to the date on which the defined violent crime/felonious assault was committed.

**Member of the Same Household** means a person who maintains residence at the same address as the Covered Person.

**Exclusions** Benefits will not be paid for treatment of any Covered Injury sustained or Covered Loss incurred during any:

1. violent crime or felonious assault committed by the Covered Person; or
2. felonious assault or violent crime committed upon the Covered Person by: a Fellow [Employee] [Member]; Family Member; or Member of the Same Household.

[{Other} exclusions that apply to this benefit are in the *Common Exclusions* Section.]]

#### **[HIV OCCUPATIONAL ACCIDENT BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the covered [Employee] [Member] suffers a Covered Injury resulting, directly and independently of all other causes, from a Covered Accident. Such Covered Accident must: occur during the performance of Occupational Duties; and result in the covered [Employee]

[Member] acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within {one year} of the Covered Injury.

In order to receive this benefit, the covered [Employee] [Member] must satisfy all of the following:

1. submit a Workers' Compensation Injury report to the Policyholder within {48 hours} of the Covered Accident that occurs during the performance of Occupational Duties;
2. test negative for Human Immunodeficiency Virus (HIV) antibodies within {48 hours} of such Covered Accident;
3. test positive for Human Immunodeficiency Virus (HIV) antibodies in a subsequent Blood Test within {one year} of the date of the Covered Accident.

**Definitions** For purposes of this benefit:

**Occupational Duties** means the performance of normal work duties on behalf of the Policyholder.

**HIV** means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

**Blood Test** means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by Us.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT**

We will pay the Covered Home Alteration and Vehicle Modification Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person suffers a Covered Loss, other than a Loss of Life, resulting directly and independently of all other causes from a Covered Accident.

This benefit will be payable if all of the following conditions are met:

1. prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
2. as a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
3. the Covered Person requires home alteration or vehicle modification within {one year} of the date of the Covered Accident.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[HOSPITAL STAY BENEFIT**

We will pay the {daily, monthly} benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires a Hospital Stay due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Hospital Stay must meet all of the following:

1. be at the direction and under the care of a Physician;
2. begin within {30 days} of the Covered Accident;
- [3. begin while the Covered Person's insurance is in effect.]

The benefit will be paid for each day of a continuous Hospital Stay that continues after the end of the Benefit Waiting Period as shown in the *Schedule of Benefits*. Benefits will be paid retroactively to the first day of the Hospital Stay. [If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[PRIVATE PASSENGER BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident while: driving; riding as a passenger in; or getting in or out of; a Private Passenger Automobile.

*Include if Accidental Death and Dismemberment Benefits are not included in the issued policy.*

[If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the Covered Loss results in death, benefits will only be paid for Loss of Life.]

**Definition** For purposes of this benefit:

**Private Passenger Automobile** means a validly registered: four wheel private passenger car (including Policyholder-owned cars); campers; motorized golf carts; motor homes; non-motorized bicycles; non-motorized adult tricycles; station wagons; sport utility vehicles; pick-up trucks; and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as: a taxicab; bus; or other public conveyance will not be considered a Private Passenger Automobile.

Any vehicle not defined above will not be considered a Private Passenger Automobile.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[REHABILITATION BENEFIT**

We will pay the Rehabilitation Benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, when the Covered Person requires rehabilitation after sustaining a Covered Loss resulting directly and independently of all other causes from a Covered Accident.

The Covered Person must require Rehabilitation within {two years} after the date of {the Covered Accident, Covered Loss}.

**Definition** For purposes of this benefit:

**Rehabilitation** means: {medical services; supplies; or treatment; or Hospital confinement (or part of a Hospital confinement)} that satisfies all of the following conditions:

1. are essential for physical rehabilitation required due to the Covered Person's Covered Loss;
2. meet generally accepted standards of medical practice;
3. are performed under: the care; supervision; or order of a Physician;
4. prepare the Covered Person to return to his or any other occupation.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

**[SEATBELT [AND AIRBAG] BENEFIT**

We will pay the benefit shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. [if airbag benefit is included: An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).]

Verification of proper use of the seatbelt at the time of the Covered Accident [and that the Supplemental Restraint System properly inflated upon impact] must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

[If: such certification or police report is not available; or it is unclear whether the Covered Person was wearing a seatbelt [or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System]; We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.]

[In the case of a child, seatbelt means: a child restraint; as required by state law and approved by the National Highway Traffic Safety Administration; properly secured; and being used as recommended by its manufacturer for children of like Age and weight at the time of the Covered Accident.]

**Definitions** For purposes of this benefit:  
[if *airbag benefit* is included: **Supplemental Restraint System** means an airbag that inflates upon impact for added protection to the head and chest areas.]

**Automobile** means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to: a sedan; station wagon; sport utility vehicle; or a motor vehicle of the pickup; van; camper; or motor-home type. Automobile does not include: a mobile home; or any motor vehicle which is used in mass or public transit.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[SPECIAL EDUCATION BENEFIT**

We will pay the benefit, up to the Maximum Benefit shown in the *Schedule of Benefits*, for each qualifying Dependent Child [and][a surviving covered Spouse] who {is/are} insured under the covered [Employee's] [Member's] certificate on the date he dies [or has been Totally Disabled during the Benefit Waiting Period for Permanent Total Disability benefits.] The Covered Person's death must result, directly and independently of all other causes from a Covered Accident for which an Accidental Death Benefit [or Permanent Total Disability Benefits] {is, are} payable under this Policy. This benefit is subject to the conditions and exclusions described below.

[A qualifying Dependent Child must:

1. a. [be enrolled as a full-time student in an accredited school of higher learning beyond the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident]; or  
b. [be at the 12<sup>th</sup> grade level on the date of the covered [Employee's] [Member's] Covered Accident and then enroll as a full-time student at an accredited school of higher learning within {365 days} from the date of the Covered Accident and continue his education as a full-time student.]
2. continue his education as a full-time student in such accredited school of higher learning; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in this Policy;
2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.]

[A qualifying surviving Dependent Child must:

1. enroll as a full-time student at a school of higher learning before reaching the limiting Age for dependent eligibility stated in this Policy;
2. continue his education as a full-time student; and
3. incur expenses for: tuition; fees; books; room and board; transportation; and any other costs: payable directly to; or approved and certified by; such school.

A qualifying surviving Spouse must:

1. enroll in any accredited school for the purpose of retraining or refreshing skills needed for employment within {one year} of the date of the covered [Employee's] [Member's] Covered Accident;
2. remain enrolled in such accredited school; and
3. incur expenses: payable directly to; or approved by; such school.]

*Always include this language:*

Payments will be made to each qualifying Dependent Child [or to the child's legal guardian, if the child is a minor] at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Dependent Child's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date the covered [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits], if the surviving Dependent Child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

[If no Dependent Child qualifies for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

[Payments will be made to the surviving Spouse at the end of each year for the number of years shown in the *Schedule of Benefits*. We must receive proof satisfactory to Us of the Spouse's enrollment and attendance within {31 days} of the end of each year. The first year for which a Special Education Benefit is payable will begin on the date the surviving Spouse enrolls in an accredited school for the first time following the date the [Employee] [Member] died [or completed the Benefit Waiting Period for Permanent Total Disability benefits]. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.]

[If a surviving Spouse does not qualify for Special Education Benefits within {365 days} of the covered [Employee's] [Member's] death [or completion of the Benefit Waiting Period for Permanent Total Disability Benefits], We will pay the default benefit shown in the *Schedule of Benefits* to the covered [Employee's] [Member's] beneficiary.]

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[TOTAL DISABILITY WEEKLY INCOME BENEFIT**

We will pay weekly benefits shown in the *Schedule of Benefits*, subject to the conditions and exclusions described below, to the Covered Person whose Total Disability results: directly and independently of all other causes from; and within {31 days} of; a Covered Accident. Weekly disability benefits will begin when the Totally Disabled Covered Person satisfies the Benefit Waiting Period shown in the *Schedule of Benefits* and will end on the earliest of the date he:

1. dies;
2. is no longer Totally Disabled;
3. fails to provide certification by a Physician that he remains Totally Disabled;
4. is eligible to receive [Accidental Death and Dismemberment benefits] [Permanent Total Disability benefits] for the same Covered Accident];
5. reaches the end of the Maximum Benefit Period shown in the *Schedule of Benefits*.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]

#### **[WAIVER OF PREMIUM BENEFIT**

We will waive premiums, beginning with those due on and after the end of the Benefit Waiting Period, for a covered [Employee] [Member] [ Spouse] who:

- a. becomes Totally Disabled [within {30 days} of] [after suffering] a Covered Loss that results directly and independently of all other causes from a Covered Accident; and

- b. satisfies all of the following conditions:
1. Total Disability must begin before the covered [Employee's] [Member's] [Spouse's] {60th} birthday;
  2. We must receive proof satisfactory to Us that Total Disability was continuous during the Benefit Waiting Period;
  3. insurance under this Policy remains in force during the Benefit Waiting Period.

The covered [Employee] [Member] must submit satisfactory proof of continuous Total Disability to Us no more than {three to 12 months} after the date he [became Totally Disabled] [satisfies the Benefit Waiting Period]. Proof of continuing Total Disability must be submitted to Us during the last {three months} of each year. We may have the covered [Employee] [Member] [Spouse] examined as often as reasonably necessary while Totally Disabled, but not more than once a year after two years.

The amount of insurance for which premiums will be waived is the amount in force on the date the covered [Employee] [Member] [Spouse] became Totally Disabled. This amount will be subject to any age reductions applicable during the Benefit Period. Any increases in coverage that would have occurred if the covered [Employee] [Member] [Spouse] were not Totally Disabled will be deferred, as described in the *Deferred Effective Dates* provision of the *Eligibility and Effective Date* section of this Policy.

Premiums will cease to be waived on the earliest of the following dates:

1. the premium due date following the date the covered [Employee] [Member] [Spouse] ceases to be Totally Disabled;
2. the date the covered [Employee] [Member] [Spouse] refuses to be examined or fails to provide required proof of continuing Total Disability;
3. the premium due date following the end of the Benefit Period shown in the *Schedule of Benefits*.

When premiums cease to be waived as described above, insurance provided under this Policy will continue as long as premiums are paid when due.

**Exclusions** The exclusions that apply to this benefit are in the *Common Exclusions* Section.]