

SERFF Tracking Number: CLTR-126453073 State: Arkansas
 Filing Company: OneBeacon America Insurance Company State Tracking Number: 44803
 Company Tracking Number: AH 650 BA CW FORM
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Blanket Accident
 Project Name/Number: Blanket Accident/AH 650 BA CW FORM

Filing at a Glance

Company: OneBeacon America Insurance Company

Product Name: Blanket Accident SERFF Tr Num: CLTR-126453073 State: Arkansas
 TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Filed- State Tr Num: 44803
 Closed

Sub-TOI: H04.000 Health - Blanket Accident/Sickness Co Tr Num: AH 650 BA CW FORM State Status: Filed-Closed

Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Stephanie Young, Linda Ryan-James, Mark Swercheck Disposition Date: 04/14/2010
 Date Submitted: 02/08/2010 Disposition Status: Filed-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Blanket Accident
 Project Number: AH 650 BA CW FORM
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 04/14/2010

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Large
 Group Market Type: Blanket
 Explanation for Other Group Market Type:
 State Status Changed: 04/14/2010
 Created By: Stephanie Young
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Linda Ryan-James

PPACA: Pre-PPACA Submission

Filing Description:

On behalf of OneBeacon America Insurance Company, Coulter and Associates is filing the captioned blanket accident program.

The program will be offered on a non-contributory and contributory basis to eligible members of defined blanket groups for covered activities/events. These forms are designed to provide Accident Only coverage on a Blanket basis. No dependents coverage is provided.

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The major benefits available are Accidental Death, Accidental Dismemberment and Accident Medical Expense related to Covered Injuries. The benefits available are described in Section IV of the Policy.

Form AH 660 BA CW 12 09 is the group application that will be completed by the policyholder. AH 653 BA CW 12 09 allows for administrative changes to be made to the policy. Examples of changes would be the addition or deletion of subsidiaries, address changes of the policyholder, or changes made to the schedule at renewal. AH 650 BA CW 12 09 is the group policy issued to the policyholder for the benefit of the eligible persons of the group. AH 652 BA CW 12 09 is the certificate issued to the Insured Persons. There are also several optional endorsements such as Home Alteration and Vehicle Modification Benefit Endorsement, Catastrophe Cash Benefit Endorsement, etc.

The Endorsement for Residents of Arkansas Only (AH 651 BA AR 12 09) contains state specific amendatory language. OneBeacon would like to have the option to issue this endorsement in one of the following manners:

1. issue the endorsement as filed; or
2. incorporate the endorsement language into the Policy/Certificate documents; or
3. incorporate the endorsement language into a countrywide endorsement reflecting the state specific changes for all approved states.

These are new forms for OneBeacon America and will not supersede any form on file with the department.

The variable statements for the bracketed language are incorporated into the documents themselves; therefore, a separate statement of variables is not included. Numerical data will comply with state minimum requirements.

If you have any questions, please call me at (609) 443-7540 or email me at Linda@coulter-and-associates.com. Otherwise we look forward to your approval.

Company and Contact

Filing Contact Information

Linda Ryan-James, Consultant linda@coulter-and-associates.com
Coulter & Associates, Inc. 609-443-7540 [Phone]
379 Princeton-Hightstown Rd. 609-443-4103 [FAX]
Suite 15
Cranbury, NJ 08512

Filing Company Information

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

OneBeacon America Insurance Company CoCode: 20621 State of Domicile: Massachusetts
1 Beacon Lane Group Code: 1129 Company Type:

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 Canton, MA 02021-1030 Group Name: OneBeacon State ID Number:
 Insurance
 (973) 630-6659 ext. [Phone] FEIN Number: 04-2475442

Filing Fees

Fee Required? Yes
 Fee Amount: \$75.00
 Retaliatory? Yes
 Fee Explanation: Massachusetts filing fee
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
OneBeacon America Insurance Company	\$75.00	02/08/2010	34060379

<i>SERFF Tracking Number:</i>	<i>CLTR-126453073</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Blanket Accident</i>		
<i>Project Name/Number:</i>	<i>Blanket Accident/AH 650 BA CW FORM</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Rosalind Minor	04/14/2010	04/14/2010
Approved-Closed	Rosalind Minor	02/12/2010	02/12/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Amendment Letter	Stephanie Young	04/14/2010	04/14/2010

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Project Name/Number: Blanket Accident/AH 650 BA CW FORM

Disposition

Disposition Date: 04/14/2010

Implementation Date:

Status: Filed-Closed

Comment:

This submission was re-opened in order to amend your letter to clarify that the product will be marketed to large and small groups.

The letter is being filed effective on this date. The forms will maintain the original approval date of 2/12/2010.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authority to File	Approved-Closed	Yes
Supporting Document	Amendment Letter	Filed-Closed	Yes
Form	Blanket Accident Insurance Policy	Approved-Closed	Yes
Form	Administrative Change Endorsement	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Catastrophe Cash Benefit Endorsement	Approved-Closed	Yes
Form	Description of Hazards Endorsement	Approved-Closed	Yes
Form	Primary/Excess Endorsement	Approved-Closed	Yes
Form	Travel Assistance Endorsement	Approved-Closed	Yes
Form	Voluntary Amendatory Endorsement	Approved-Closed	Yes
Form	Home Alteration and Vehicle Modification	Approved-Closed	Yes
	Benefit Endorsement		
Form	Blanket Accident Certificate of Insurance	Approved-Closed	Yes
Form	Mandatory Endorsement for Arkansas Residents	Approved-Closed	Yes

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Disposition

Disposition Date: 02/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Amendment Letter

Submitted Date: 04/14/2010

Comments:

Attached is an amendment letter which clarifies that this program will be marketed to both large and small eligible defined blanket groups.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Amendment Letter

Comment:

AR Amendment Filing Letter 4-14-2010.pdf

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Form Schedule

Lead Form Number: AH 650 BA CW 12 09

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/12/2010	AH 650 BA CW 12 09	Policy/Cont ract/Fratern al	Blanket Accident Insurance Policy Certificate	Initial		0.000	Blanket Accident Policy.pdf
Approved-Closed 02/12/2010	AH 653 BA CW 12 09	Policy/Cont ract/Fratern al	Administrative Change Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	Blanket Accident Administrative Change Endorsement. pdf
Approved-Closed 02/12/2010	AH 660 BA CW 12 09	Application/ Enrollment Form	Application	Initial		0.000	Blanket Accident Application.pdf
Approved-Closed 02/12/2010	AH 656 BA CW 12 09	Policy/Cont ract/Fratern al	Catastrophe Cash Benefit Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	Blanket Accident Catastrophe Cash Benefit Endorsement. pdf
Approved-Closed 02/12/2010	AH 655 BA CW 12 09	Policy/Cont ract/Fratern al	Description of Hazards Endorsement Certificate: Amendmen	Initial		0.000	Blanket Accident Hazards Endorsement. pdf

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<i>Product Name:</i>	<i>Blanket Accident</i>		
<i>Project Name/Number:</i>	<i>Blanket Accident/AH 650 BA CW FORM</i>		

Approved- Closed 02/12/2010	AH 659 BA CW 12 09	Policy/Cont Primary/Excess ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	Blanket Accident Primary- Excess Endorsement. pdf
Approved- Closed 02/12/2010	AH 658 BA CW 12 09	Policy/Cont Travel Assistance ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	Blanket Accident Travel Assistance Endorsement. pdf
Approved- Closed 02/12/2010	AH 654 BA CW 12 09	Policy/Cont Voluntary ract/Fratern Amendatory al Endorsement Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	Blanket Accident Voluntary Amendatory Endorsement. pdf
Approved- Closed 02/12/2010	AH 657 BA CW 12 09	Policy/Cont Home Alteration and ract/Fratern Vehicle Modification al Benefit Endorsement Certificate: Amendmen t, Insert Page,	Initial	0.000	Blanket Accident Home and Vehicle Alteration Endorsement. pdf

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<i>Product Name:</i>	<i>Blanket Accident</i>		
<i>Project Name/Number:</i>	<i>Blanket Accident/AH 650 BA CW FORM</i>		
	Endorseme nt or Rider		
Approved- Closed 02/12/2010	AH 652 BA Certificate CW 12 09 Insurance	Blanket Accident Certificate of Insurance	Initial 0.000
Approved- Closed 02/12/2010	AH 651 BA Policy/Cont AR 12 09 ract/Fratern al Arkansas Residents Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Mandatory Endorsement for Arkansas Residents.pdf	Initial



BLANKET ACCIDENT INSURANCE POLICY
FOR
[POLICYHOLDER]

IMPORTANT NOTICE

**THIS BLANKET POLICY PROVIDES COVERAGE FOR LOSSES
DUE TO ACCIDENTS ONLY**

**IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR
LOSSES DUE TO SICKNESS.**

This Policy is a Legal Contract between the Policyholder and the Insurer.

Please read this Policy carefully.

OneBeacon America Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: [Name]
[Street]
[City, State Zip]

POLICY NUMBER: [XXX-XXX-XXX]

POLICY EFFECTIVE DATE: [January 1, 2010]

[POLICY TERMINATION DATE: [January 1, 2011]] (in or out based on plan purchased)

This Policy is a legal contract between the Policyholder and the Insurer. The Insurer agrees to insure Eligible Persons of the Policyholder, for whom premium is paid, against loss covered by this Policy, subject to its provisions, limitations and exclusions.

This Policy takes effect on the Policy Effective Date. All periods of insurance begin and end when 12:01 AM, Standard Time occurs at the Policyholder's address. This Policy remains in force for the period for which premium has been paid.

This Policy is governed by the laws of the state in which [it is delivered] (OR) [the **Policyholder** is located].

In Witness Whereof, We have caused this Policy to be executed and attested.



Dennis R. Smith, Secretary
OneBeacon America Insurance Company



Michael Miller, President & CEO
OneBeacon America Insurance Company

READ THIS POLICY CAREFULLY

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[CATASTROPHE CASH BENEFIT ENDORSEMENT.....#[3]]	(in or out based on plan purchased)
[PRIMARY/EXCESS ENDORSEMENT.....#[4]]	(in or out based on plan purchased)
[VOLUNTARY AMENDATORY ENDORSEMENT.....#[5]]	(in or out based on plan purchased)

SECTION I – SCHEDULE OF BENEFITS

ELIGIBLE PERSONS:

- Class 1: [All active, registered [team members] (OR) [campers] (OR) [students] (OR) [members] of the **Policyholder**] (OR)
[All individuals actively participating in the [Covered Activities] [and] (OR) [Covered Events] indicated below] (OR)
[All active [firefighters] (OR) [police officers] of the **Policyholder**] (OR)
[All active members of [XXX] [Organization] (OR) [Association] (OR) [League] (OR) [Club]]
- [Class 2: [All [equipment managers,] (AND/OR) [coaches,] (AND/OR) [assistant coaches,] (AND/OR) [scorekeepers,] (AND/OR) [trainers,] (AND/OR) [officials of the league] [and] (AND/OR) [volunteers] working on behalf of the **Policyholder**] (OR)
[All [chaperones,] (AND/OR) [leaders,] (AND/OR) [instructors,] (AND/OR) [counselors,] (AND/OR) [volunteers,] [and] (AND/OR) [coaches] assisting at the [Covered Activities] [and] (OR) [Covered Events] indicated below]] (Class 2 will be in or out based on plan purchased)
- [An individual may only be covered under one Class.] (in or out based on plan purchased)

COVERAGE:

- [[Amateur] (OR) [Intercollegiate] Sports Accident Coverage] (OR)
[[Day] (OR) [Overnight] [Camp] (OR) [Sports Clinic] Accident Coverage] (OR)
[[Martial Arts] (OR) [Fitness] (OR) [Cardio Kickboxing] (OR) [Dance School] Accident Coverage] (OR)
[Firefighters Accident Coverage] (OR)
[High School Football Accident Coverage] (OR)
[Police Officers Accident Coverage] (OR)
[[Club] (OR) [Association] (OR) **Policyholder**] Sponsored [Activities] [and] (AND/OR) [Events] Accident Coverage]

COVERED ACTIVITIES:

- [Fighting Fires at the direction and on behalf of the **Policyholder**] (OR)
[Intramural Games and Practices [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Extra-Curricular Sports [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Intercollegiate Sports [organized, supervised and] sponsored by the **Policyholder**] (OR)
[[Martial Arts,] (OR) [Dance,] (OR) [Fitness] (OR) [Cardio Kickboxing] (OR) [Baseball,] (OR) [T-Ball] (OR) [Basketball,] (OR) [Soccer,] (OR) [Softball,] (OR) [Cricket] (OR) [Cheerleading] (OR) [Volleyball,] (OR) [Football,] (OR) [[Flag] (OR) [Touch] Football] (OR) [Ice Hockey,] (OR) [Field Hockey] (OR) [Golf,] (OR) [Lacrosse,] (OR) [Cross Country,] (OR) [Roller Hockey,] (OR) [Rugby,] (OR) [Track,] (OR) [Wrestling,] (OR) [Bowling,] (OR) [Band,] (OR) [Music] (OR) [Horseback Riding,] (OR) [Swimming,] (OR) [Tennis] [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Games and Practices [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Sports [Camps] (OR) [Clinics]] (OR)
[[Police Officers'] (OR) [Fire Fighters'] activities performed at the direction and on behalf of the **Policyholder**] (OR)
[any activity [organized, supervised and] sponsored by the **Policyholder**]]
(AND/OR)

COVERED EVENTS:

- [Specific Social Event(s) [organized, supervised and] sponsored by the **Policyholder**] (OR)
[[Championship Competitions] (AND/OR) [Tournaments] [organized, supervised and] sponsored by the **Policyholder**] (OR)
[[Firefighter's] (OR) [Policemen's] Ball] (OR)
[Campers' Parents Day] (OR)

SECTION II – ELIGIBILITY, EFFECTIVE AND TERMINATION DATES

ELIGIBILITY FOR INSURANCE

Each person in one of the eligible Classes shown on the **Schedule** is eligible to be insured on the **Policy** Effective Date, or the day he or she becomes eligible, if later. **We** maintain the right to investigate and determine if coverage applies. If **We** discover coverage eligibility requirements are not met, **We** shall offer to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

An **Eligible Person** will be insured on the later of the **Policy** Effective Date or the date he or she is eligible, if not required to contribute to the cost of this insurance.

TERMINATION DATE OF INSURANCE

An **Insured Person's** coverage will end on the earlier of the date:

1. the **Policy** terminates;
2. the **Insured Person** is no longer eligible; or
3. the period ends for which premium is paid.

SECTION III – PREMIUM

Premium Due Date: [February 1, 2010] (OR)
[February 1, 2010 and the 1st of each month thereafter for the previous month of coverage]

Premium Amount: [Annual Premium of [\$00,000]] (OR)
[Monthly Premium of [\$ 00.00] [per **Insured Person**]]

Grace Period: A Grace Period of [thirty (30), forty-five (45), sixty (60)] days will be provided for the payment of any premium due after the first premium. This **Policy** will not be terminated for nonpayment of premium during the Grace Period if the **Policyholder** pays all premiums due by the last day of the **Policy** Grace Period. This **Policy** will terminate on the premium due date if all premiums due are not paid by the last day of the **Policy** Grace Period.

If **We** expressly agree to accept late payment of a premium without terminating this **Policy**, **We** do so in accordance with the Noncompliance With **Policy** Requirements provision on the GENERAL PROVISIONS Section of this **Policy**. In such case, the **Policyholder** will be liable to **Us** for any unpaid premiums for the time this **Policy** is in force, plus all costs and expenses (including, but not limited to, reasonable attorney fees, collection fees and court costs) incurred by **Us** in the collection of all overdue amounts.

No Grace Period will be provided if **We** receive notice to terminate this **Policy** prior to a premium due date.]

SECTION IV – DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH BENEFIT

If an **Insured Person** sustains a **Covered Injury** while participating in a **[Covered Activity]** [or] **[Covered Event]**,] resulting in death within the **Accident Commencement Period** shown on the **Schedule**, **We** will pay the **Principal Sum** also shown on the **Schedule**, subject to the terms, conditions, limitations and exclusions of this **Policy**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If the **Insured Person** suffers an **Accidental Death** such that an **Accidental Death Benefit** is payable under this **Policy**, **We** will pay the beneficiary in accordance with the Payment of Claims provision.

[Exposure and Disappearance

If an **Insured Person** is exposed to weather because of an **Accident** while participating in a **[Covered Activity]** [or] **[Covered Event]**,] and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum** shown on the **Schedule**, subject to the terms, conditions, limitations and exclusions of this **Policy**.

If the body of an **Insured Person** has not been found within [90, 180, 365] days after the disappearance, stranding, sinking or wrecking of a vehicle in which that person was an occupant, while participating in a **[Covered Activity]** [or] **[Covered Event]**,] then it will be presumed, subject to all other terms and provisions of this **Policy**, that the **Insured Person** has suffered **Accidental Death** within the meaning of this **Policy**. If the **Insured Person** is subsequently found alive and identified, **We** have the right to recover any benefits paid.] (in or out based on plan purchased)

ACCIDENTAL DISMEMBERMENT BENEFIT

If an **Insured Person** sustains a **Covered Injury** while participating in a **[Covered Activity]** [or] **[Covered Event]**,] resulting in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown on the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below, subject to the terms, conditions, limitations and exclusions of this **Policy**.

<u>For Covered Loss of:</u>	<u>Percentage of the Principal Sum</u>
Any combination of two:	
Hands, Feet, Sight, [Speech] [and] [Hearing]	[50, 75, 100]%
One Hand or One Foot	[25, 50, 75]%
Sight of One Eye	[25, 50, 75]%
[Speech] [or] [Hearing (in both ears)].....	[25, 50, 75]%
Thumb and Index Finger of Same Hand	[10, 15, 25]%

For purposes of this benefit:

Covered Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Covered Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. [**Covered Loss** of speech means total and irrecoverable loss of the entire ability to speak.] [**Covered Loss** of hearing in an ear means total and irrecoverable loss of the entire hearing in that ear.] **Covered Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If more than one **Covered Loss** is sustained by an **Insured Person** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

ACCIDENT MEDICAL EXPENSE BENEFIT

If an **Insured Person** sustains a **Covered Injury** while participating in a **[Covered Activity]** [or] **[Covered Event]**,] that requires him or her to obtain **Covered Accident Medical Services**, within the **Medical Commencement Period** shown on the **Schedule**, **We** will pay the **Usual and Customary Charges** incurred for the **Covered Accident Medical Services** received due to that **Covered Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown on the **Schedule**, per **Insured Person**, for all **Covered Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**, the **Accident Medical Expense Benefit** limitations indicated on the **Schedule** and the **LIMITATIONS** section of this **Policy**, and the terms, conditions, limitations and exclusions of this **Policy**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Covered Injury**. The **Deductible Amount** for the **Accident Medical Expense Benefit** is the **Deductible Amount** shown on the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Covered Injuries** sustained by the **Insured Person** in that **Covered Accident**.

SECTION V – HAZARDS INSURED AGAINST

We will pay benefits described in this **Policy** when an **Insured Person** suffers a **Covered Loss** as a result of a **Covered Accident** during one of the [Covered Activities] [or] [Covered Events] listed on the **Schedule**. We will only pay benefits if the **Insured Person** is engaged in one of the hazards described below when the **Covered Accident** occurs. Unless otherwise specified, **We** pay benefits only once for any one **Covered Accident**, even if it is covered by more than one hazard.

[[AMATEUR] (OR) [INTERCOLLEGIATE] SPORTS ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while the **Insured Person** is:

1. participating as a member of the team in a scheduled competition or exhibition game, or practice or training session; [or]
2. [serving as an [equipment manager,] (AND/OR) [coach,] (AND/OR) [assistant coach,] (AND/OR) [scorekeeper,] (AND/OR) [trainer] or (AND/OR) [volunteer worker] for the team;] (Class 2 will be in or out based on plan purchased) [or]
3. [traveling to or from a [scheduled competition or exhibition game,] or [practice or training session] while in a team furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travels less than [two (2) – twenty-four (24)] hours each way [beginning when the **Insured Person** leaves home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event] [or] [Activity]** before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home] (in or out based on plan purchased).]] (in if #3 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan

purchased)

(OR)

HIGH SCHOOL FOOTBALL ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while the **Insured Person** is:

1. a registered student of the **Policyholder** and an active member of the **Policyholder's** football team; [or]
2. [serving as an [equipment manager,] (AND/OR) [coach,] (AND/OR) [assistant coach,] (AND/OR) [scorekeeper,] (AND/OR) [trainer] or (AND/OR) [volunteer worker] for the team;] (Class 2 will be in or out based on plan purchased) [and]
3. practicing or participating in regularly scheduled high school organized, sponsored and supervised football games, or practice or training sessions; [or]
4. [traveling to or from school organized, sponsored and supervised football activities while in a school furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travels less than [two (2) – twenty-four (24)] hours each way [beginning when the **Insured Person** leaves home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] [**Activity**] before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home)] (in or out based on plan purchased).]] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

Aircraft Restrictions

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

(OR)

[[CLUB] (OR) [ASSOCIATION] (OR) [POLICYHOLDER] SPONSORED [ACTIVITIES] [EVENTS] COVERAGE (in or out based on plan purchased)

The **Covered Accident** must occur either:

1. on the premises of the [Club] (OR) [Association] (OR) [Policyholder] during normal hours of operation; or
2. on the premises of the [Club] (OR) [Association] (OR) [Policyholder] during other periods of time if attending or participating in a [Club] (OR) [Association] (OR) [Policyholder] [organized, supervised and] sponsored **Covered [Activity]** [or] **[Event]**; or
3. away from the premises of the [Club] (OR) [Association] (OR) [Policyholder] while attending or participating in a [Club] (OR) [Association] (OR) [Policyholder] [organized, supervised and] (in or out based on plan purchased) sponsored **Covered [Activity]** [or] **[Event]** at such [activity's] (OR) [event's] scheduled site.

[The **Covered [Activity]** [or] **[Event]** includes travel* without deviation or interruption between the premises of the [Club] (OR) [Association] (OR) [Policyholder] or other meeting place it designates, and the site of such **Covered [Activity]** [or] **[Event]**.] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the [Club] (OR) [Association] (OR) [Policyholder]; [and]
2. [travels less than [two (2) – twenty-four (24)] hours each way [beginning when the **Insured Person** leaves home:] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] **[Activity]**, before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home)] (in or out based on plan purchased).] (in if paragraph referenced above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

(OR)

[[DAY] (OR) [OVERNIGHT] [CAMP] (OR) [SPORTS CLINIC] ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while the **Insured Person** is:

1. a registered [camper] (OR) [athlete] of the **Policyholder**; [or]
2. [serving as a [coach,] (AND/OR) [assistant coach,] (AND/OR) [counselor,] (AND/OR) [assistant counselor,] or (AND/OR) [volunteer worker] for the **Policyholder**;] (Class 2 will be in or out based on plan purchased) and
3. participating in [camp] (OR) [clinic] **Covered [Events]** [or] [**Activities**] organized, sponsored and supervised by the **Policyholder**; [or]
4. [traveling to or from **Policyholder** organized, sponsored and supervised **Covered [Events]** [or] [**Activities**] while in a **Policyholder** furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travels less than [two (2) – twenty-four (24)] hours each way [beginning when the **Insured Person** leaves home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] [**Activity**] before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home)] (in or out based on plan purchased).]] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[**Aircraft Restrictions**

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan purchased)

(OR)

[**MARTIAL ARTS**] (OR) [**FITNESS**] (OR) [**CARDIO KICKBOXING**] (OR) [**DANCE SCHOOL**] **ACCIDENT COVERAGE** (in or out based on plan purchased)

The **Covered Accident** must take place while the **Insured Person** is:

1. a registered student of the **Policyholder**; [or]
2. [serving as an [instructor,] (AND/OR) [assistant instructor,] (AND/OR) [record keeper,] (AND/OR) [scheduler] or (AND/OR) [volunteer worker] for the **Policyholder**;] (Class 2 will be in or out based on plan purchased) [and]
3. participating in regularly scheduled instructional or exhibition classes, practices or shows organized, sponsored and supervised by the **Policyholder**; [or]

4. [traveling to or from **Policyholder** organized, sponsored and supervised events or activities while in a **Policyholder** furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] [over the age of 25] who is under the direct supervision of the **Policyholder**; and
2. travels less than [24 hours] each way [beginning when the **Insured Person** leaves home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event] [or] Activity** before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home] (in or out based on plan purchased).]

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan purchased)

(OR)

[FIRE FIGHTERS ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while the **Insured Person** is:

1. [an employee] (OR) [a volunteer] of the **Policyholder**; and
2. fighting fires at the direction and on behalf of the **Policyholder**; [or]
3. [performing other duties of a fire fighter on [or off] (in or out based on plan purchased) the premises of the **Policyholder** at the direction and on behalf of the **Policyholder**;] [or]
4. [traveling to or from the scene of a fire [or the location of a duty described in #3.] (in or out based on plan purchased) in a vehicle furnished by the **Policyholder**.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travels less than [two (2) – twenty-four (24)] hours each way [beginning when the **Insured Person** leaves home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]**

[or] [Activity] before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home] (in or out based on plan purchased).]] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

(OR)

POLICE OFFICERS ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while the **Insured Person** is:

1. [an employee] (OR) [a volunteer] of the **Policyholder**; and
2. [performing the duties of a police officer on assignments off the premises of the **Policyholder** at the direction and on behalf of the **Policyholder**;] (in or out based on plan purchased) [or]
3. [performing the duties of a police officer on the premises of the **Policyholder** at the direction and on behalf of the **Policyholder**;] (in or out based on plan purchased) [or]
4. [patrolling his or her assigned district in a vehicle furnished by the **Policyholder**.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in this **Policy**, provided the **Insured Person**:

1. is in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travels less than [two (2) – twenty-four (24)] hours each way [beginning when the **Insured Person** leaves home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] [Activity] before it starts and/or after it finishes; [and ending when the **Insured Person** arrives home]] (in or out based on plan purchased).]] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident**

occurred, to be intoxicated, if operating a motor vehicle.

- b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while the **Insured Person** is riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. he or she is riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan purchased)

SECTION VI – LIMITATIONS

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated on the **Schedule**.

Accidental Death and Accidental Dismemberment [and Catastrophe Cash] Benefits Limitations.

The most We will pay for the following benefits, in total, is the **Insured Person's Principal Sum**, if the **Insured Person** can recover benefits under the **Accidental Death Benefit** and the **Accidental Dismemberment Benefit** [and the **Catastrophe Cash Benefit**] (used if **Catastrophe Cash Benefit Endorsement is included in Policy**) as a result of the same **Covered Accident**.

Accident Medical Expense Benefit Limitations

1. The **Maximum Benefit Amount** for the **Accident Medical Expense Benefit** shall apply to all **Covered Injuries** sustained by an **Insured Person** as a result of a single **Covered Accident**.
2. **Covered Accident Medical Services** shall only apply to services that are **Medically Necessary**.
3. The **Accident Medical Expense Benefit** shall only apply for charges incurred before the expiration of the **Maximum Benefit Period**.
4. [The **Covered Accident Medical Services** are subject to all limits shown on the **Schedule** which may include limitations on certain categories of benefits or types of services.] (in or out based on plan purchased)
5. [Benefits pursuant to the **Accident Medical Expense Benefit** are payable in excess of any expenses payable by **Other Valid and Collectible Insurance**, subject to this **Policy Deductible Amount** as indicated on the **Schedule** being met. In absence of **Other Valid and Collectible Insurance**, payments under this **Accident Medical Expense Benefit** shall be payable, subject to the terms, conditions, limitations and exclusions of this **Policy**.] (used when benefits are excess, not primary)

[Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated on the **Schedule**.] (in or out based on plan purchased)

[Maximum Benefit Amount per Policy Period

We will not pay more than the **Maximum Benefit Amount per Policy Period** stated on the **Schedule**.] (in or out based on plan purchased)

SECTION VIII –TERMINATION OF POLICY

This **Policy** will terminate at 12:01 A.M. Local Time at the **Policyholder's** address on the earliest of:

1. [the premium due date if premiums are not paid when due subject to the Grace Period, except for the initial premium due which is not subject to the Grace Period;] (in or out based on plan purchased)
2. [the Policy Termination Date shown on page 2 of this **Policy**;] (may be used if plan is Voluntary)
3. the date We discover that the **Policyholder** provided material fraudulent information in obtaining the **Policy**; [or]
4. [the date specified on the written notice of the **Policyholder's** intent to terminate this **Policy**, which will be at least [thirty (30), sixty (60), ninety (90)] days after the date the **Policyholder** sends such notice to Us.] (in or out based on plan purchased)

If **We** terminate this **Policy**, any unearned premium will be returned on a pro-rata basis. If the **Policyholder** requests termination, **We** will return any unearned premium paid on a pro-rata basis.

Termination will not affect any claim for a **Covered Loss** occurring prior to the effective date of termination.

SECTION IX – CLAIMS PROVISIONS

Notice. The **Insured Person** or the beneficiary, or someone on their behalf, must give **Us** written notice of the loss within twenty (20) days of such loss. The notice must name the **Insured Person** and the **Policy** Number. To request a claim form, the **Insured Person** or the beneficiary, or someone on their behalf may contact **Us** at [866-568-2233]. The notice must be sent to the Claims Department at OneBeacon America Insurance Company, [P.O. Box 1009, Morristown, NJ 07962-1009], or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.

Claim Forms. **We** will send the claimant Proof of Loss (claim) forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the forms in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and the extent of the loss. **We** will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss. The notice should include the **Insured Person's** name, the **Policyholder's** name and the **Policy** number.

Proof of Loss. Written Proof of Loss, acceptable to **Us**, must be sent within ninety (90) days of the date of the loss. If the loss is one for which this **Policy** requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as **We** may reasonably require. Failure to furnish Proof of Loss, acceptable to **Us**, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible. and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. **We** have a right to investigate the Proof of Loss and any relevant documents which the **Insured Person** or the beneficiary, or someone on their behalf, will make available to **Us** upon request.

Time of Payment. **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which this **Policy** provides any periodic payment, [within [fifteen (15), thirty (30), forty-five (45)] days] **(OR)** [immediately upon receipt] of written Proof of Loss that is acceptable to **Us**.

[Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each [one (1), two (2)] week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.] **(in or out based on plan purchased)**

Recipient of Payment.

1. Loss of Life. **Covered Losses** resulting from the **Insured Person's** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as the **Insured Person**, **We** will pay the benefit to the **Insured Person's** survivors in the following order:
 - a. [the **Insured Person's** legally married spouse;] **(used only when adults covered)**
 - b. [the **Insured Person's** child(ren);] **(used only when adults covered)**
 - c. the **Insured Person's** parents;
 - d. the **Insured Person's** brothers and sisters;
 - e. the **Insured Person's** estate.
2. All Other Claims. Benefits are paid to the **Insured Person** unless a minor or not able to give a valid release. [The **Insured Person** or his or her legal representative may direct in writing that all or part of an **Accident Medical Expense Benefit** be paid directly to the party who furnished the service. The direction may be changed by the **Insured Person** or his or her legal representative at any time up to the filing of the Proof of Loss.] **(in or out based on plan purchased)** If an **Insured Person** dies before all payments due have been made, the amount still payable will be paid to his or her beneficiary, or if there is no beneficiary designated, as set forth above, then to his or her estate.

Physical Examination and Autopsy. **We** have the right to examine an **Insured Person**, whose **Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If an **Insured Person** suffers a **Covered Loss(es)** as the result of **Covered Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under this **Policy**. However, if the **Insured Person**, beneficiary or any other person receives payment from the third party, the **Insured Person**, beneficiary or any other person agrees to refund to **Us** the lesser of: (1) the amount actually paid by **Us** for such **Covered Loss(es)**; or (2) an amount equal to the sum actually received from the third party for such **Covered**

Loss(es). If the **Insured Person**, beneficiary or any other person does not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of this **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, arbitration or otherwise. This provision will not apply where prohibited by law.

Sunset. In no event will a claim made for losses sustained by an **Insured Person** be considered valid and collectible in accordance with this **Policy** unless full details of such claim are presented to **Us** within three (3) years from the date of the **Accident** which is the basis of such claim.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of this **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to the **Insured Person** (and his or her assignee) under this **Policy** to the extent of the overpayment.

[Suit Against Us. No action on this **Policy** may be brought until sixty (60) days after written Proof of Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina, Wisconsin and Alabama) of the date the written Proof of Loss was required to be submitted. If the law of the state where the **Insured Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.] (in or out based on plan purchased)

[Arbitration. Any contest to a claim denial under this **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Insured Person** or the person claiming to be the beneficiary. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Insured Person** or the person claiming to be the beneficiary is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if this **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of any individual or class action lawsuit brought by the **Insured Person**, his or her legal representative, or beneficiary.] (in or out based on plan purchased)

[Subrogation. **We** have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to the **Insured Person**, beneficiary or any other person from anyone liable for the **Covered Injury**. If the **Insured Person**, beneficiary or any other person recovers from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to the **Insured Person**, beneficiary or any other person. The **Insured Person**, beneficiary or any other person agrees to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.] (in or out based on plan purchased)

SECTION X – GENERAL PROVISIONS

Beneficiaries. The **Insured Person** or his or her legal representative has the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. The **Insured Person** or his or her legal representative may change the beneficiary at any time. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to **Us**.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at **Our** option, to any relative by blood or connection by marriage of the payee, who, in **Our** opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs

Change or Waiver. A change or waiver of any terms or conditions of this **Policy** must be issued by **Us** in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under this **Policy** will not be deemed as a waiver of such rights in the same or future situations.

Certificates. We will give to the **Policyholder** a **Certificate**, in either paper or electronic format, for their **Insured Persons** where required by state law. The **Policyholder** will either give or make these **Certificates** available to the **Insured Persons** or their legal representatives. Such **Certificate** will contain a summary of terms that affect benefits.] (in or out based on plan purchased)

Clerical Error. A clerical error or omission, whether by the **Policyholder**, the Producer, or **Us**, will not increase or continue **Blanket Accident** coverage, which otherwise would not be in force. If an **Insured Person** or his or her legal representative applies for insurance for which he or she is not eligible, **We** will only be liable for any premiums paid to **Us**.

Conformity With Statute. Terms of this **Policy** that conflict with the laws of the state [where it is delivered] (OR) [of **Policyholder's** address on the **Policy**] are amended to conform to such laws.

Entire Contract. This **Policy**, together with any riders, endorsements, amendments, applications, completed enrollment materials and attached papers, if any, make up the entire contract between the **Policyholder** and **Us**. In the absence of fraud, all statements made by the **Policyholder** or any **Insured Person** or his or her legal representative will be considered representations and not warranties. No written statement made by an **Insured Person** will be used in any contest unless a copy of the statement is furnished to the **Insured Person** or his or her beneficiary or legal representative.

Policyholder Records/Audit. The **Policyholder** will keep a record of the coverage, premium and other pertinent administrative information for each **Insured Person**. **We** may examine these records at reasonable times while the **Policy** is in force and for six (6) years after the termination of the **Policy**. **We** reserve the right to charge or refund premium, as applicable. The **Policyholder** will report to **Us**, within a reasonable time, all changes in information regarding an **Insured Person**. [The **Policyholder** will indemnify **Us** for any benefits or other payments that are caused in whole or in part by the **Policyholder's** negligence or error in performing the record keeping function. In addition, the **Policyholder** will be liable for any retroactive premium.] (in or out based on plan purchased)

Data Required. The **Policyholder** and the Producer must maintain adequate records acceptable to **Us** and provide any information required by **Us** relating to this insurance.

Assignment of Interest. This **Policy** is non-assignable.

Incontestability. The validity of this **Policy** will not be contested, except as to nonpayment of premiums or due to a material fraudulent misstatement in obtaining the insurance.

Noncompliance With Policy Requirements. Any express waiver by **Us** of any requirements of this **Policy** will not constitute a continuing waiver of such requirements. Any failure by **Us** to insist upon compliance with any **Policy** provision will not operate as a waiver or amendment of that provision.

SECTION XI – GENERAL DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.
- **Accident Commencement Period** means the time period, shown on the **Schedule**, between the date of the **Accident** which caused the **Injury** and the date the **Loss** must occur for death or dismemberment benefits to be payable under this **Policy**.
- **Aggregate Limit of Liability** means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in this **Policy**. For purposes of the Aggregate Limit of Liability provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] (in or out based on plan purchased) and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each **Insured Person**, **We** will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- **Ambulatory Medical Center** means a facility that meets all of the following requirements:
 1. operates under the laws of the state that it is situated in;
 2. has a staff of **Physicians** and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
 3. provides continuous **Physician** and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An **Ambulatory Medical Center** does not include a **Hospital** or a **Physician's** office or a clinic.
- [**Combined Single Limit** means, with respect to any one **Insured Person**, the total amount of benefits that are payable under this **Policy** for or in connection with a **Covered Injury** sustained as the result of any one **Covered Accident**. When the **Combined Single Limit** has been reached, no further benefits will be payable under this **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident**.] (in or out based on plan purchased)
- **Covered Accident** means an **Accident** that occurs while the **Insured Person** is participating in a [**Covered Activity**] [or] [**Covered Event**] and results in a **Covered Loss**.
- **Covered Accident Medical Services** means the following services, provided that they are **Medically Necessary**:
 1. treatment by a **Physician**, or a licensed practical nurse or RN;
 2. treatment in a **Hospital** semi-private room and board (or room and board in an intensive care unit), including **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;
 3. services for **Home Health Care**;
 4. ambulance, including air ambulance, service to or from a **Hospital** for one (1) round trip;
 5. laboratory tests;
 6. radiological procedures;
 7. anesthetics and the administration of anesthetics;
 8. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
 9. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the **Dental Maximum**, if any shown on the **Schedule**.

Payment for the purchase or maintenance of eyeglasses, contact lenses or hearing aids or the examination for the prescription or fitting thereof shall not be considered a Covered Accidental Medical Expense.
- [**Covered Activity(ies)** means the activity(ies) listed on the **Schedule**.] (in or out based on plan purchased)
- [**Covered Event(s)** means the event(s) listed on the **Schedule**.] (in or out based on plan purchased)

- **Covered Injury** means bodily harm or bodily damage that results from a **Covered Accident**, is independent of all other causes, occurs while the **Insured Person** is insured under this **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**.
- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services**, incurred due to **Covered Injuries** sustained by an **Insured Person** in a **Covered Accident**, which must be met before the **Accident Medical Expense Benefit** will be paid. The **Deductible Amount** is shown on the **Schedule**.
- **Eligible Person** means a person who is described on the **ELIGIBLE PERSONS** section of the **Schedule**.
- **Home Health Care** means nursing care and treatment of an **Insured Person** in his or her home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:
 1. be approved in writing by the attending **Physician**;
 2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
 3. begin within [three (3), five (5), seven (7), ten (10)] days after discharge from a **Hospital**; and
 4. follow a **Hospital** confinement of [three (3), five (5), seven (7)] days or more.

No benefits are payable for **Home Health Care** services provided by:

 1. a member of an **Insured Person's** immediate family; or
 2. a person residing in the **Insured Person's** home.
- **Hospital** means a facility that: (1) operates under the law of the state that it is situated in; (2) is approved by the Department of Health and Human Services or its successor; (3) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (4) has 24-hour nursing service by graduate registered nurses (RN), on duty or on call; and (5) is supervised by one or more **Physicians**. A **Hospital** does not include: (1) a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the **Hospital** that is used for such purposes; or (3) any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.
- **Immediate Family Member** means a person who is related to the **Insured Person** in any of the following ways: [Spouse,] (in or out based on plan purchased) brother-in-law, sister-in-law, [son-in-law, daughter-in-law, mother-in-law, father-in-law,] (in or out based on plan purchased) parent (includes stepparent), brother or sister (includes stepbrother or stepsister), [or child (includes legally adopted or placed for adoption, or stepchild)] (in or out based on plan purchased) or any person residing in the **Insured Person's** home.
- **Insured Person** means a person who is an **Eligible Person** for whom premium has been paid.
- **Maximum Benefit Period** means, with respect to the **Accident Medical Expense Benefit**, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The **Maximum Benefit Period** for the **Accident Medical Expense Benefit** commences on the first date of treatment or service and continues for the period of time shown on the **Schedule**.
- **Medical Commencement Period** means the time period shown on the **Schedule** between the date of the **Accident** that caused the **Covered Injury** and the date that the first **Covered Accident Medical Service** must be incurred for **Accident Medical Expense** benefits to be payable under this **Policy**
- **Medically Necessary** means that a **Covered Accident Medical Service**: (1) is essential for diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a **Physician** and performed under his or her care supervision or order. **Medically Necessary** will not include personal comfort or convenience items.
- **[Other Valid and Collectible Insurance** means any plan providing medical expense benefits for or by reason of dental, physician, nurse, hospital care, treatment or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by: (1) any type of service plan contracts, any health maintenance organization or

subscriber contracts, any group or blanket insurance, employee benefit plan or plans arranged through an employer, trustee, union, employee benefit association or professional association; (2) any plan or program created or administered by the national or a state government, or agencies thereof; or (3) any individual insurance plan.] (may be used when plan is Voluntary)

- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) [the **Insured Person**]; (in or out based on plan purchased) (2) an **Immediate Family Member**; or (3) a practitioner retained by the **Policyholder**.
- **Policy** means this **Blanket Accident Insurance Policy**.
- **Policyholder** is the group named on the front page of this **Policy**.
- [**Pre-Existing Condition** means a condition for which an **Insured Person** has sought or received medical advice or treatment during the [three (3), six (6), twelve (12), eighteen (18)] months immediately preceding his or her effective date of [coverage under this **Policy**] (OR) [a **Covered Injury**].] (in or out based on plan purchased)
- **Principal Sum** means the amount of insurance listed on the **Schedule**. The **Accidental Death and Accidental Dismemberment** benefits are based upon this amount.
- **Schedule** is SECTION I of this **Policy**.
- **Sound Natural Teeth** means natural teeth that are either unaltered or fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.
- **Usual and Customary Charge(s)** means a charge that is made for a **Covered Accident Medical Expense Benefit** that: (1) does not include charges that would not have been made if no insurance existed; (2) is the lesser of the: (a) usual charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred. (For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit.) or (b) the allowable charge as calculated by any **Other Valid and Collectible Insurance** provider; and (3) with respect to drugs, [[75 - 150%] of the Average Wholesale Price (AWP)] [[75 - 150%] of the generic drug price] [[75 - 150%] of the Average Sales Price (ASP)] will be considered Usual and Customary.
- **We, Us, and Our** refers to OneBeacon America Insurance Company.

Policyholder: [Name]
Policy Number: [XXX-XXX-XXX]
Policy Effective Date: [January 1, 2010]

Underwritten by: OneBeacon America Insurance Company



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

ADMINISTRATIVE CHANGE ENDORSEMENT

It is hereby understood and agreed that as of the effective date indicated above the following changes are made to this **Policy**:

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.

Handwritten signature of Dennis R. Smith in black ink.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Handwritten signature of Michael Miller in black ink.

Michael Miller, President & CEO
OneBeacon America Insurance Company



Group Application

Application is hereby made for a plan of **Blanket Accident Insurance** based on the following statements and representations:

SECTION I – GENERAL INFORMATION

Policyholder Name: _____
Physical Address: _____ City: _____
State: _____ Zip Code: _____
Mailing Address: _____ City: _____
State: _____ Zip Code: _____
Contact Person: _____ Title: _____
Office Phone: _____ Fax: _____
Cell Phone: _____ Home Phone: _____
Email: _____ Website: _____
Type of Business: _____
Number of years in business: _____

SECTION II – INSURANCE INFORMATION

Current Insurance Company: _____ Annual Premium: _____

Desired Effective Date: _____ to _____

Have you had a liability claim in last 5 years? _____ Yes _____ No

If yes, please provide date, amount paid and brief description: _____

Type of Person(s) to be Covered: _____

Number of Persons to be Covered: _____

Events/Activities to be Covered: _____

Who pays for this Coverage? _____ Policyholder _____ Insured

Benefits Requested:

Accidental Death Benefit

Principal Sum: _____ \$[10,000] _____ \$[25,000] _____ \$[50,000] other \$ _____

Accidental Dismemberment Benefit

Principal Sum: _____ \$[15,000] _____ \$[30,000] _____ \$[75,000] other \$ _____

Accident Medical Expense Benefits

Maximum Benefit Amount: _____ \$[10,000] _____ \$[25,000] _____ \$[60,000] other \$ _____

[Optional Benefits Available:

- Travel Assistance Benefit ___ Yes ___ No
- Catastrophe Cash Benefit ___ Yes ___ No
Maximum Benefit Amount: ___\$[25,000] ___\$[50,000] ___\$[100,000] other \$_____
- Home & Vehicle Alteration Benefit ___ Yes ___ No]

(Underwriter will determine \$ choices to offer based on type of hazard application is being used - hazards are defined in the policy document)

SECTION III – UNDERWRITER INFORMATION

1. Do you have a Release/Waiver on file for each person to be covered? * ___ Yes ___ No
If so, are parents/guardians signatures required for minors when appropriate? ___ Yes ___ No
2. Do you have a written crisis management plan? ___ Yes ___ No
3. Do you have a written medical emergency plan? ___ Yes ___ No
4. Do you use special equipment for the events/activities to be covered? ___ Yes ___ No
If so, please list: _____
5. Do you charge an entrance fee to attend your events/activities? ___ Yes ___ No
6. Do your events/activities involve overnights? ___ Yes ___ No
7. Do you hold any of the following:
Performances/Recitals? ___ Yes ___ No Number Annually _____
Fundraisers? ___ Yes ___ No Number Annually _____
Special Events? ___ Yes ___ No Number Annually _____

* A signed release and waiver form is required for all participants or parents of minors, if applicable. Coverage is contingent upon having procedures in place that require the signing of a valid release and waiver of liability by all participants or parents of participants, if applicable. Participant liability coverage will not apply if this is not in place.

IMPORTANT NOTE:

Any person with the intent to knowingly defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that is related to the acceptance of the risk by the insurer, may be guilty of insurance fraud and may be subject to prosecution.

The Policyholder represents the information contained in this application is true and correct and forms the basis of the requested insurance.

Policyholder's Signature: _____ Date: _____

Title: _____

Agency Information

Agency Name: _____ License Number: _____

Agency Address: _____ City: _____

State: _____ Zip Code: _____

Contact: _____

Phone: _____ Email: _____



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

CATASTROPHE CASH BENEFIT ENDORSEMENT

If an **Insured Person** sustains a **Covered Injury** [while participating in a [Covered Activity] [or] [Covered Event],] (in or out based on plan purchased) resulting in any type of **Covered Loss** specified below, within the **Accident Commencement Period** shown on the **Schedule**, We will pay a benefit, subject to the terms, conditions, limitations and exclusions of this **Policy**. In order for such benefit to be payable, the **Covered Loss** must continue for the **Waiting Period** shown on the **Schedule**, must be determined by a **Physician** to be permanent and irreversible at the end of that **Waiting Period**, and must result in **Disability**. The benefit payable is based on the percentage of the [Initial Lump Sum and] [Monthly] Maximum Amount(s), as stated on the **Schedule**, shown below for the following causes of **Disability**:

<u>Cause of Disability</u>	<u>Percentage of [Initial Lump Sum and] [Monthly] Maximum Amount(s)</u>
[Coma	[50, 75, 100]%] (in or out based on plan purchased)
Quadriplegia	[50, 75, 100]%
Paraplegia	[25, 50, 66 2/3, 75]%
Hemiplegia	[25, 50, 66 2/3, 75]%
[Uniplegia	[10, 15, 25]%] (in or out based on plan purchased)

If the **Insured Person** suffers more than one cause of **Disability** as a result of the same **Covered Accident**, only one Percentage of the Maximum Amount, the largest for any one cause of **Disability** suffered by the **Insured Person**, will be used to determine the benefit payable.

The benefit payable is

[LUMP SUM:]

the percentage of the **Principal Sum** shown above, payable at the end of the **Waiting Period**.]

(OR)

[MONTHLY:]

a monthly benefit equal to the percentage of the Monthly Amount shown above, starting at the end of the **Waiting Period**. The benefit is payable monthly as long as the **Insured Person** remains continuously **Disabled** due to the **Paralysis** or **Coma**, but ceases on the earlier[r/st] of: (1) the date the **Insured Person** dies; [or] (2) the date the **Insured Person** is no longer **Disabled** due to the **Paralysis** or **Coma**;; or (3) the date monthly Catastrophe Cash Benefits have been paid for the Maximum Number of Months shown on the **Schedule** for the Catastrophe Cash Benefit].]

(OR)

[LUMP SUM THEN MONTHLY:]

the percentage of the Initial Lump Sum Amount shown above, payable at the end of the **Waiting Period**; followed by a monthly benefit equal to the percentage of the Monthly Amount shown above, starting one month after the end of the **Waiting Period**. The monthly benefit is payable monthly as long as the **Insured Person** remains continuously **Disabled** due to the **Paralysis** or **Coma**, but ceases on the earlier[r/st] of: (1) the date the **Insured Person** dies; [or] (2) the date the **Insured Person** is no longer **Disabled** due to the **Paralysis** or **Coma**;; or (3) the date monthly Catastrophe Cash Benefits have been paid for the Maximum Number of Months shown on the **Schedule** for the Catastrophe Cash Benefit].]

[If the **Insured Person** [returns to any occupation for which he or she is qualified by reason of education, experience or training on a full or part-time basis, he or she may return to **Disability** status if: (1) the **Insured Person** has not been back to work for longer than thirty (30) days; and (2) the attending **Physician** certifies a return to **Disability** status due to the same **Paralysis** or **Coma** which caused the original **Disability**.] (used when adults covered) [However, with respect to an **Insured Person** for whom the occupational definition of **Disabled/Disability** is not appropriate, if the **Insured Person** [engages in any of the usual activities of a person of like age and sex in comparable health, he or she may return to **Disability** status if: (1) the **Insured Person** has not been engaging in such activities for longer than thirty (30) days; and (2) the attending **Physician** certifies a return to **Disability** status due to the same **Paralysis** or **Coma** which caused the original **Disability**.] (used when youth covered)]

Periods of **Disability** separated by less than thirty (30) consecutive days will be considered one period of **Disability** unless due to separate and unrelated causes.

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

Additional Definitions

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

Disabled/Disability means that the **Insured Person** is unable while under the regular care of a **Physician**, to [perform the material and substantial duties of any occupation for which he or she is qualified by reason of education, experience or training.] (used when adults covered) [However, with respect to an **Insured Person** for whom an occupational definition of **Disabled/Disability** is not appropriate, **Disabled/Disability** means, as used in this Endorsement, that the **Insured Person** is unable, while under the regular care of a **Physician**, to] [engage in any of the usual activities of a person of like age and sex whose health is comparable to that of the **Insured Person** immediately prior to the accident.] (used when youth covered)

Hemiplegia means the complete and irreversible **Paralysis** of the upper and lower **Limbs** of the same side of the body.

Limb means entire arm or entire leg.

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

Paraplegia means the complete and irreversible **Paralysis** of both lower **Limbs**.

Quadriplegia means the complete and irreversible **Paralysis** of both upper and both lower **Limbs**.

Uniplegia means the complete and irreversible **Paralysis** of one **Limb**.

Waiting Period means the amount of time a **Covered Loss** potentially eligible for benefits under the Catastrophe Cash Benefit must continue, as stated on the **Schedule**, before such Catastrophe Cash Benefit will be paid. The **Waiting Period** begins on the date the **Covered Loss** is sustained and must continue without interruption.

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.



Dennis R. Smith, Secretary
OneBeacon America Insurance Company



Michael Miller, President & CEO
OneBeacon America Insurance Company



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

DESCRIPTION OF HAZARDS ENDORSEMENT

This **Policy** insures against the following hazards:

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.

A handwritten signature in black ink that reads "Dennis R. Smith".

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

A handwritten signature in black ink that reads "Michael Miller".

Michael Miller, President & CEO
OneBeacon America Insurance Company



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

PRIMARY/EXCESS ENDORSEMENT

Item 5. of the **Accident Medical Expense Benefit Limitations** section of **SECTION VI – LIMITATIONS** is deleted in its entirety and replaced with:

5. For **Covered Loss(es)** pursuant to the **Accident Medical Expense Benefit**, the insurance under this **Policy** shall be the primary coverage for the first \$[100, 250, 500, 750, 1,000] of each **Covered Loss**. For amounts above \$[100, 250, 500, 750, 1,000], the benefits pursuant to the **Accident Medical Expense Benefit** shall be payable in excess of any expenses payable by **Other Valid and Collectible Insurance**. In absence of **Other Valid and Collectible Insurance**, payments under this **Accident Medical Expense Benefit** shall be payable, subject to the terms, conditions, limitations and exclusions of this **Policy**.

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.

Handwritten signature of Dennis R. Smith in black ink.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Handwritten signature of Michael Miller in black ink.

Michael Miller, President & CEO
OneBeacon America Insurance Company



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

TRAVEL ASSISTANCE ENDORSEMENT

Travel Assistance will be available to an **Insured Person** while on a **Covered Trip**, as defined below. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. However, for certain expenses, if it is not reasonably practicable for the **Insured Person** to contact **Us** for pre-authorization, the **Insured Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses [as indicated below] [not to exceed \$[250, 500, 750, 1,000]]. Under this **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation

If an **Insured Person** sustains a **Covered Injury** while on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with the appropriate medical care required for such **Covered Injury**, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Insured Person** to contact **Us** for pre-authorization, the **Insured Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed \$[250, 500, 750, 1,000]. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for this benefit is \$[10,000, 25,000.00, 50,000].]

Assisted Return of Insured Person

If an **Insured Person** sustains a **Covered Injury** while on a **Covered Trip** and has sufficiently recovered to travel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Insured Person** to the **Insured Person's Principal Residence**, in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Insured Person** to contact **Us** for pre-authorization, the **Insured Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed \$[250, 500, 750, 1,000]. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel, if required, which are covered. [The maximum amount **We** will pay for this benefit is \$[7,500, 12,500, 25,000].]

Return of Remains

If an **Insured Person** sustains a **Covered Injury** which results in his or her death while on a **Covered Trip**, and is eligible for the **Accidental Death Benefit** under the **Policy**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its place of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. However, if it is not reasonably practicable for pre-authorization to be done, reimbursement, at **Our** discretion, for appropriate covered expenses not to exceed \$[250, 500, 750, 1000], may be made. [The maximum amount **We** will pay for this benefit is \$[1,500, 2,500.00, 3,500].]

Visit to Hospital

If an **Insured Person** sustains a **Covered Injury** which results in his or her hospitalization for more than [three (3), five (5), seven (7), ten (10)] consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, the transportation for the person chosen by the **Insured Person** to visit such **Insured Person** while he or she is hospitalized. **We** must pre-authorize the transportation for benefits to be payable. [However, if it is not reasonably practicable for the **Insured Person** to contact **Us** for pre-authorization, the **Insured Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed \$[250, 500, 750, 1,000].] [The maximum amount **We** will pay for this benefit is \$[1,500, 2,500.00, 3,500].]

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VII General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with appropriate medical care required for such **Covered Injury**. **We** have sole discretion in making that determination;
3. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Insured Person** to another hospital or medical facility. **We** have sole discretion in making that determination;
4. based upon the medical condition of the **Insured Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED RETURN is not appropriate. **We** have sole discretion in making that determination;
5. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
6. **We** did not pre-authorize the transportation and/or services. However, for certain expenses, if it is not reasonably practicable for the **Insured Person** to contact **Us** for pre-authorization, the **Insured Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses [as indicated above] [not to exceed \$[250, 500, 750, 1,000]].

- **[TRAVEL ASSISTANCE LIMITATIONS**

Aggregate Limit of Liability per Covered Accident

\$[100,000, 250,000, 500,000]]

- **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of **Travel Assistance** only, the following definitions apply:

Covered Trip means when an **Insured Person** is traveling [more than [[50, 75, 100] miles] from his or her **Principal Residence**] [outside of the U.S.] [during a **Covered Activity**] [for a **Covered Event**] and such travel is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

Principal Residence means the legal domicile of the **Insured Person**.

For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy**, the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

[Right of Recovery

We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance**. **We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.]

[Excess Coverage

Our obligation to pay the **Policyholder** or **Insured Person** under **Travel Assistance** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance**.]

[Reservation of Rights

We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.]

[Exempted Countries

This Travel Assistance Plan is not available in the following countries: [named high risk countries]. **We** further reserve **Our** rights to modify this list upon [seven (7), ten (10), fifteen (15), thirty (30)] days notice to the **Policyholder**.]

[To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call [1-866-670-6693] from the U.S. or Canada; and collect from anywhere else in the world at [+1-973-630-6693].]

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.



Dennis R. Smith, Secretary
OneBeacon America Insurance Company



Michael Miller, President & CEO
OneBeacon America Insurance Company



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

VOLUNTARY AMENDATORY ENDORSEMENT

1. The definition of **Insured Person** in **SECTION XI – GENERAL DEFINITIONS** of this **Policy** is deleted and replaced by the following:

- **Insured Person** means a person who is an **Eligible Person** who has completed enrollment materials for coverage under this **Policy**, if required, and for whom premium has been paid.

2. **SECTION II – ELIGIBILITY, EFFECTIVE AND TERMINATION DATES** of this **Policy** is deleted and replaced by the following:

ELIGIBILITY FOR INSURANCE

Each person in one of the eligible Classes shown on the **Schedule** is eligible to be insured on the **Policy** Effective Date, or the day he or she becomes eligible, if later, provided his or her completed enrollment materials, if required, are received by the **Policyholder** on or prior thereto. **We** maintain the right to investigate and determine if coverage applies. If **We** discover coverage eligibility requirements are not met, **We** shall offer to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

An **Eligible Person** will be insured on the later of the **Policy** Effective Date or the date he or she is eligible, provided completed enrollment materials, if required, as well as the first premium, have been received by the **Policyholder** on or prior thereto.

TERMINATION DATE OF INSURANCE

An **Insured Person's** coverage will end on the earlier of the date:

1. the **Policy** terminates;
2. the **Insured Person** is no longer eligible;
3. the period ends for which premium is paid; or
4. the **Insured Person** requests, in writing, that his or her coverage be terminated.

3. [Any reference in this **Policy** to "Excess Benefits" is deleted and replaced by "Primary Benefits".] (in or out based on plan purchased)

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.

Handwritten signature of Dennis R. Smith in black ink.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Handwritten signature of Michael Miller in black ink.

Michael Miller, President & CEO
OneBeacon America Insurance Company



Policyholder: [Name]

Effective Date of Endorsement: [January 1, 2010]

Policy Number: [XXX-XXX-XXX]

This Endorsement is attached to and made part of this **Policy** as of the effective date indicated above. It applies only with respect to accidents that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this Endorsement.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ENDORSEMENT

We will pay an additional benefit for Home Alterations and/or Vehicle Modifications, if an **Insured Person** sustains a **Covered Injury** resulting in a **Covered Loss** that is payable under the **Accidental Dismemberment Benefit** [or the **Catastrophe Cash Benefit**], (in or out based on plan purchased) provided:

1. the **Insured Person** is required to use a wheelchair to be ambulatory on a permanent basis;
2. the **Covered Injury** that caused the payment of the **Accidental Dismemberment Benefit** [or the **Catastrophe Cash Benefit**] (in or out based on plan purchased) is the same **Covered Injury** that requires the **Insured Person** to need the wheelchair; and
3. the cost is incurred within [90, 180, 365] days of the **Covered Loss**.

The amount We will pay will be equal to:

1. the one time cost of alterations to the **Insured Person's** primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. presentation of proof of payment is provided to Us.

The maximum amount payable under all provisions of this benefit combined will be \$[2,500, 5,000, 10,000, 15,000].

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

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested.

Handwritten signature of Dennis R. Smith in black ink.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Handwritten signature of Michael Miller in black ink.

Michael Miller, President & CEO
OneBeacon America Insurance Company



**BLANKET ACCIDENT
CERTIFICATE OF INSURANCE**

FOR

**INSURED PERSONS OF
[POLICYHOLDER]**

IMPORTANT NOTICE

**THIS INSURANCE PROVIDES COVERAGE FOR LOSSES
DUE TO ACCIDENTS ONLY**

**IT DOES NOT PROVIDE COVERAGE FOR SICKNESS OR
LOSSES DUE TO SICKNESS.**

OneBeacon America Insurance Company
1 Beacon Lane
Canton, MA 02021-1030

POLICYHOLDER: [Name]
POLICY NUMBER: [XXX-XXX-XXX]

The insurance evidenced by this Certificate provides Accident insurance only. It does not provide Coverage for sickness. This Certificate describes the main features of the Policy, but the Policy is the only contract under which benefit payments are made. If there is an inconsistency between the Certificate and the Policy, the Policy will govern.

**BLANKET ACCIDENT
CERTIFICATE OF INSURANCE**

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SECTION I – SCHEDULE OF BENEFITS

CERTIFICATE HOLDER.

- Class 1: [All active, registered [team members] (OR) [campers] (OR) [students] (OR) [members] of the **Policyholder**] (OR)
[All individuals actively participating in the [Covered Activities] [and] (OR) [Covered Events] indicated below] (OR)
[All active [firefighters] (OR) [police officers] of the **Policyholder**] (OR)
[All active members of [XXX] [Organization] (OR) [Association] (OR) [League] (OR) [Club]]
- [Class 2: [All [equipment managers,] (AND/OR) [coaches,] (AND/OR) [assistant coaches,] (AND/OR) [scorekeepers,] (AND/OR) [trainers,] (AND/OR) [officials of the league] [and] (AND/OR) [volunteers] working on behalf of the **Policyholder**] (OR)
[All [chaperones,] (AND/OR) [leaders,] (AND/OR) [instructors,] (AND/OR) [counselors,] (AND/OR) [volunteers,] [and] (AND/OR) [coaches] assisting at the [Covered Activities] [and] (OR) [Covered Events] indicated below]] (Class 2 will be in or out based on plan purchased)
- [You may only be covered under one Class.] (in or out based on plan purchased)

- COVERAGE:** [[Amateur] (OR) [Intercollegiate] Sports Accident Coverage] (OR)
[[Day] (OR) [Overnight] [Camp] (OR) [Sports Clinic] Accident Coverage] (OR)
[[Martial Arts] (OR) [Fitness] (OR) [Cardio Kickboxing] (OR) [Dance School] Accident Coverage] (OR)
[Firefighters Accident Coverage] (OR)
[High School Football Accident Coverage] (OR)
[Police Officers Accident Coverage] (OR)
[[Club] (OR) [Association] (OR) **Policyholder**] Sponsored [Activities] [and] (AND/OR) [Events] Accident Coverage]

- COVERED ACTIVITIES:** [Fighting Fires at the direction and on behalf of the **Policyholder**] (OR)
[Intramural Games and Practices [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Extra-Curricular Sports [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Intercollegiate Sports [organized, supervised and] sponsored by the **Policyholder**] (OR)
[[Martial Arts,] (OR) [Dance,] (OR) [Fitness] (OR) [Cardio Kickboxing] (OR) [Baseball,] (OR) [T-Ball] (OR) [Basketball,] (OR) [Soccer,] (OR) [Softball,] (OR) [Cricket] (OR) [Cheerleading] (OR) [Volleyball,] (OR) [Football,] (OR) [[Flag] (OR) [Touch] Football] (OR) [Ice Hockey,] (OR) [Field Hockey] (OR) [Golf,] (OR) [Lacrosse,] (OR) [Cross Country,] (OR) [Roller Hockey,] (OR) [Rugby,] (OR) [Track,] (OR) [Wrestling,] (OR) [Bowling,] (OR) [Band,] (OR) [Music] (OR) [Horseback Riding,] (OR) [Swimming,] (OR) [Tennis] [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Games and Practices [organized, supervised and] sponsored by the **Policyholder**] (OR)
[Sports [Camps] (OR) [Clinics]] (OR)
[[Police Officers’] (OR) [Fire Fighters’] activities performed at the direction and on behalf of the **Policyholder**] (OR)
[any activity [organized, supervised and] sponsored by the **Policyholder**]]
(AND/OR)

- COVERED EVENTS:** [Specific Social Event(s) [organized, supervised and] sponsored by the **Policyholder**] (OR)
[[Championship Competitions] (AND/OR) [Tournaments] [organized, supervised and] sponsored by the **Policyholder**] (OR)
[[Firefighter’s] (OR) [Policemen’s] Ball] (OR)
[Campers’ Parents Day] (OR)

SECTION II – ELIGIBILITY, EFFECTIVE AND TERMINATION DATES

ELIGIBILITY FOR INSURANCE

If **You** are in one of the eligible Classes shown on the **Schedule**, **You** are eligible to be insured on the **Policy** Effective Date, or the day **You** become eligible, if later. **We** maintain the right to investigate and determine if coverage applies. If **We** discover coverage eligibility requirements are not met, **We** shall offer to refund any premium paid for **You**.

EFFECTIVE DATE OF INSURANCE

You will be insured on the later of the **Policy** Effective Date or the date **You** are eligible, if not required to contribute to the cost of this insurance.

TERMINATION DATE OF INSURANCE

As an **Insured Person**, **Your** coverage will end on the earlier of the date:

1. the **Policy** terminates;
2. **You** are no longer eligible; or
3. the period ends for which premium is paid.

SECTION III – DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH BENEFIT

If **You** sustain a **Covered Injury** while participating in a [[**Covered Activity**] [or] [**Covered Event**],] resulting in death within the **Accident Commencement Period** shown on the **Schedule**, **We** will pay the **Principal Sum** also shown on the **Schedule**, subject to the terms, conditions, limitations and exclusions of the **Policy**. The **Accident Commencement Period** starts on the date of the **Accident** that caused such **Injury**. If **You** suffer an **Accidental Death** such that an **Accidental Death Benefit** is payable under the **Policy**, **We** will pay **Your** beneficiary in accordance with the Payment of Claims provision.

[Exposure and Disappearance

If **You** are exposed to weather because of an **Accident** while participating in a [**Covered Activity**] [or] [**Covered Event**],] and this results in a **Covered Loss**, **We** will pay the applicable **Principal Sum** shown on the **Schedule**, subject to the terms, conditions, limitations and exclusions of the **Policy**.

If **Your** body has not been found within [90, 180, 365] days after the disappearance, stranding, sinking or wrecking of a vehicle in which **You** were an occupant, while participating in a [**Covered Activity**] [or] [**Covered Event**],] then it will be presumed, subject to all other terms and provisions of this **Policy**, that **You** have suffered **Accidental Death** within the meaning of the **Policy**. If **You** are subsequently found alive and identified, **We** have the right to recover any benefits paid.] (in or out based on plan purchased)

ACCIDENTAL DISMEMBERMENT BENEFIT

If **You** sustain a **Covered Injury** while participating in a [**Covered Activity**] [or] [**Covered Event**],] resulting in any one of the **Covered Losses** specified below, within the **Accident Commencement Period** shown on the **Schedule**, **We** will pay the Percentage of the **Principal Sum** indicated below, subject to the terms, conditions, limitations and exclusions of the **Policy**.

<u>For Covered Loss of:</u>	<u>Percentage of the Principal Sum</u>
Any combination of two:	
Hands, Feet, Sight, [Speech] [and] [Hearing]	[50, 75, 100]%
One Hand or One Foot	[25, 50, 75]%
Sight of One Eye	[25, 50, 75]%
[Speech] [or] [Hearing (in both ears)].....	[25, 50, 75]%
Thumb and Index Finger of Same Hand	[10, 15, 25]%

For purposes of this benefit:

Covered Loss of a hand or foot means complete severance through or above the wrist or ankle joint. **Covered Loss** of sight of an eye means total and irrecoverable loss of the entire sight in that eye. [**Covered Loss** of speech means total and irrecoverable loss of the entire ability to speak.] [**Covered Loss** of hearing in an ear means total and irrecoverable loss of the entire hearing in that ear.] **Covered Loss** of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

If **You** sustain more than one **Covered Loss** as a result of the same **Covered Accident**, only one amount, the largest, will be paid.

ACCIDENT MEDICAL EXPENSE BENEFIT

If **You** sustain a **Covered Injury** while participating in a [**Covered Activity**] [or] [**Covered Event**],] that requires **You** to obtain **Covered Accident Medical Services**, within the **Medical Commencement Period** shown on the **Schedule**, **We** will pay the **Usual and Customary Charges** incurred for the **Covered Accident Medical Services** received due to that **Covered Injury**, up to the **Maximum Benefit Amount** and **Maximum Benefit Period** shown on the **Schedule**, per **Insured Person**, for all **Covered Injuries** caused by a single **Covered Accident**, subject to any applicable **Deductible Amount**, the **Accident Medical Expense Benefit** limitations indicated on the **Schedule** and the **LIMITATIONS** section of the **Policy**, and the terms, conditions, limitations and exclusions of the **Policy**.

The **Medical Commencement Period** starts on the date of the **Accident** that caused such **Covered Injury**. The **Deductible Amount** for the **Accident Medical Expense Benefit** is the **Deductible Amount** shown on the **Schedule**, if any, which must be met from **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services** incurred due to **Covered Injuries You** sustained in that **Covered Accident**.

SECTION IV – HAZARDS INSURED AGAINST

We will pay benefits described in the **Policy** when **You** suffer a **Covered Loss** as a result of a **Covered Accident** during one of the [**Covered Activities**] [or] [**Covered Events**] listed on the **Schedule**. **We** will only pay benefits if **You** are engaged in one of the hazards described below when the **Covered Accident** occurs. Unless otherwise specified, **We** pay benefits only once for any one **Covered Accident**, even if it is covered by more than one hazard.

[[AMATEUR] (OR) [INTERCOLLEGIATE] SPORTS ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while **You** are:

1. participating as a member of the team in a scheduled competition or exhibition game, or practice or training session; [or]
2. [serving as an [equipment manager,] (AND/OR) [coach,] (AND/OR) [assistant coach,] (AND/OR) [scorekeeper,] (AND/OR) [trainer] or (AND/OR) [volunteer worker] for the team;] (Class 2 will be in or out based on plan purchased) [or]
3. [traveling to or from a [scheduled competition or exhibition game,] or [practice or training session] while in a team furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

1. are in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travel less than [two (2) – twenty-four (24)] hours each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event] [or] [Activity]**

before it starts and/or after it finishes; [and ending when **You** arrive home] (in or out based on plan purchased).]] (in if #3 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

(OR)

HIGH SCHOOL FOOTBALL ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while **You** are:

1. a registered student of the **Policyholder** and an active member of the **Policyholder's** football team; [or]
2. [serving as an [equipment manager,] (AND/OR) [coach,] (AND/OR) [assistant coach,] (AND/OR) [scorekeeper,] (AND/OR) [trainer] or (AND/OR) [volunteer worker] for the team;] (Class 2 will be in or out based on plan purchased) [and]
3. practicing or participating in regularly scheduled high school organized, sponsored and supervised football games, or practice or training sessions; [or]
4. [traveling to or from school organized, sponsored and supervised football activities while in a school furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

1. are in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travel less than [two (2) – twenty-four (24)] hours each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] [**Activity**] before it starts and/or after it finishes; [and ending when **You** arrive home]] (in or out based on plan purchased).]] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.

- b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
- 2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

- 1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
- 2. the aircraft has a valid certificate of airworthiness; and
- 3. the aircraft is flown by a pilot with a valid license; and
- 4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
- 5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

(OR)

[[CLUB] (OR) [ASSOCIATION] (OR) [POLICYHOLDER] SPONSORED [ACTIVITIES] [EVENTS] COVERAGE (in or out based on plan purchased)

The **Covered Accident** must occur either:

- 1. on the premises of the [Club] (OR) [Association] (OR) [**Policyholder**] during normal hours of operation; or
- 2. on the premises of the [Club] (OR) [Association] (OR) [**Policyholder**] during other periods of time if attending or participating in a [Club] (OR) [Association] (OR) [**Policyholder**] [organized, supervised and] sponsored **Covered [Activity]** [or] [**Event**]; or
- 3. away from the premises of the [Club] (OR) [Association] (OR) [**Policyholder**] while attending or participating in a [Club] (OR) [Association] (OR) [**Policyholder**] [organized, supervised and] (in or out based on plan purchased) sponsored **Covered [Activity]** [or] [**Event**] at such [activity's] (OR) [event's] scheduled site.

[The **Covered [Activity]** [or] [**Event**] includes travel* without deviation or interruption between the premises of the [Club] (OR) [Association] (OR) [**Policyholder**] or other meeting place it designates, and the site of such **Covered [Activity]** [or] [**Event**].] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

- 1. are in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the [Club] (OR) [Association] (OR) [**Policyholder**]; [and]
- 2. [travel less than [two (2) – twenty-four (24)] hours each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] [**Activity**], before it starts and/or after it finishes; [and ending when **You** arrive home]] (in or out based on plan purchased).]] (in if paragraph referenced above is in)

[**We** will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

- 1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
- 2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in

accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

(OR)

[DAY] (OR) [OVERNIGHT] [CAMP] (OR) [SPORTS CLINIC] ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while **You** are:

1. a registered [camper] (OR) [athlete] of the **Policyholder**; [or]
2. [serving as a [coach,] (AND/OR) [assistant coach,] (AND/OR) [counselor,] (AND/OR) [assistant counselor,] or (AND/OR) [volunteer worker] for the **Policyholder**;] (Class 2 will be in or out based on plan purchased) and
3. participating in [camp] (OR) [clinic] **Covered [Events]** [or] [**Activities**] organized, sponsored and supervised by the **Policyholder**; [or]
4. [traveling to or from **Policyholder** organized, sponsored and supervised **Covered [Events]** [or] [**Activities**] while in a **Policyholder** furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

1. are in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travel less than [two (2) – twenty-four (24)] hours each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event]** [or] [**Activity**] before it starts and/or after it finishes; [and ending when **You** arrive home)] (in or out based on plan purchased).]] (in if #4 above is in)

[**We** will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and

3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder’s** affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan purchased)

(OR)

[MARTIAL ARTS] (OR) [FITNESS] (OR) [CARDIO KICKBOXING] (OR) [DANCE SCHOOL] ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while **You** are:

1. a registered student of the **Policyholder**; [or]
2. [serving as an [instructor,] (AND/OR) [assistant instructor,] (AND/OR) [record keeper,] (AND/OR) [scheduler] or (AND/OR) [volunteer worker] for the **Policyholder**;] (Class 2 will be in or out based on plan purchased) [and]
3. participating in regularly scheduled instructional or exhibition classes, practices or shows organized, sponsored and supervised by the **Policyholder**; [or]
4. [traveling to or from **Policyholder** organized, sponsored and supervised events or activities while in a **Policyholder** furnished vehicle.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

1. are in a vehicle operated by a properly licensed driver [age 21 or over] [over the age of 25] who is under the direct supervision of the **Policyholder**; and
2. travel less than [24 hours] each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event] [or] Activity** before it starts and/or after it finishes; [and ending when **You** arrive home] (in or out based on plan purchased).]

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver’s intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the

Policyholder, or any of the **Policyholder's** affiliates. An aircraft will be deemed "controlled" by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan purchased)

(OR)

FIRE FIGHTERS ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while **You** are:

1. [an employee] (OR) [a volunteer] of the **Policyholder**; and
2. fighting fires at the direction and on behalf of the **Policyholder**; [or]
3. [performing other duties of a fire fighter on [or off] (in or out based on plan purchased) the premises of the **Policyholder** at the direction and on behalf of the **Policyholder**;] [or]
4. [traveling to or from the scene of a fire [or the location of a duty described in #3.] (in or out based on plan purchased) in a vehicle furnished by the **Policyholder**.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

1. are in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travel less than [two (2) – twenty-four (24)] hours each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event] [or] [Activity]** before it starts and/or after it finishes; [and ending when **You** arrive home] (in or out based on plan purchased).] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder's** affiliates. An aircraft will be deemed "controlled" by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]]] (in or out based on plan purchased)

(OR)

POLICE OFFICERS ACCIDENT COVERAGE (in or out based on plan purchased)

The **Covered Accident** must take place while **You** are:

1. [an employee] (OR) [a volunteer] of the **Policyholder**; and

2. [performing the duties of a police officer on assignments off the premises of the **Policyholder** at the direction and on behalf of the **Policyholder**;) (in or out based on plan purchased) [or]
3. [performing the duties of a police officer on the premises of the **Policyholder** at the direction and on behalf of the **Policyholder**;) (in or out based on plan purchased) [or]
4. [patrolling **Your** assigned district in a vehicle furnished by the **Policyholder**.*] (in or out based on plan purchased)

[* Benefits for a **Covered Accident** that occurs while traveling are paid as described in the **Policy**, provided **You**:

1. are in a vehicle operated by a properly licensed driver [age 21 or over] (OR) [over the age of 25] who is under the direct supervision of the **Policyholder**; [and]
2. [travel less than [two (2) – twenty-four (24)] hours each way [beginning when **You** leave home;] (in or out based on plan purchased) including any time spent on the premises of the **Covered [Event] [or] [Activity]** before it starts and/or after it finishes; [and ending when **You** arrive home)] (in or out based on plan purchased).] (in if #4 above is in)

[We will not pay a benefit if the driver of the above referenced vehicle, at the time of the **Covered Accident** is either:

1. under the influence of alcohol;
 - a. He or she will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Covered Accident** occurred, to be intoxicated, if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver’s intoxication. Or,
2. under the influence of a poison, fume, noxious chemical substance that was deliberately ingested; or a prescription drug unless taken as prescribed by a **Physician**; or a non-prescription drug, unless taken in accordance with its directions.] (in or out based on plan purchased)

[Aircraft Restrictions

If the **Covered Accident** occurs while **You** are riding in, or getting on or off of, an aircraft, **We** will pay benefits, but only if:

1. **You** are riding as a passenger only, and not as a pilot or member of the crew; and
2. the aircraft has a valid certificate of airworthiness; and
3. the aircraft is flown by a pilot with a valid license; and
4. the aircraft is not being used for: (i) crop dusting, spraying, or seeding; 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 which 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).
5. the aircraft is a military transport aircraft flown by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

[Owned Aircraft Not Covered – Benefits will not be paid if the aircraft is owned, leased or controlled by the **Policyholder**, or any of the **Policyholder**’s affiliates. An aircraft will be deemed “controlled” by the **Policyholder** if the **Policyholder** may use it for more than 10 straight days, or more than 15 days in any year.]] (in or out based on plan purchased)

SECTION V – LIMITATIONS

Aggregate Limit of Liability.

We will not pay more than the **Aggregate Limit of Liability** stated on the **Schedule**.

Accidental Death and Accidental Dismemberment [and Catastrophe Cash] Benefits Limitations.

The most **We** will pay for the following benefits, in total, is **Your Principal Sum**, if **You** can recover benefits under the **Accidental Death Benefit** and the **Accidental Dismemberment Benefit** [and the **Catastrophe Cash Benefit**] (used if **Catastrophe Cash Benefit Endorsement is included in Policy**) as a result of the same **Covered Accident**.

Accident Medical Expense Benefit Limitations

1. The **Maximum Benefit Amount** for the **Accident Medical Expense Benefit** shall apply to all **Covered Injuries You** sustained as a result of a single **Covered Accident**.
2. **Covered Accident Medical Services** shall only apply to services that are **Medically Necessary**.
3. The **Accident Medical Expense Benefit** shall only apply for charges incurred before the expiration of the **Maximum Benefit Period**.
4. [The **Covered Accident Medical Services** are subject to all limits shown on the **Schedule** which may include limitations on certain categories of benefits or types of services.] (in or out based on plan purchased)
5. [Benefits pursuant to the **Accident Medical Expense Benefit** are payable in excess of any expenses payable by **Other Valid and Collectible Insurance**, subject to the **Policy Deductible Amount** as indicated on the **Schedule** being met. In absence of **Other Valid and Collectible Insurance**, payments under this **Accident Medical Expense Benefit** shall be payable, subject to the terms, conditions, limitations and exclusions of the **Policy**.] (used when benefits are excess, not primary)

[Combined Single Limit.

We will not pay more than the **Combined Single Limit** stated on the **Schedule**.] (in or out based on plan purchased)

[Maximum Benefit Amount per Policy Period

We will not pay more than the **Maximum Benefit Amount per Policy Period** stated on the **Schedule**.] (in or out based on plan purchased)

SECTION VI – GENERAL EXCLUSIONS

The **Policy** does not cover any losses caused in whole or in part by, or resulting in whole or in part from, the following:

- suicide or any attempt at suicide; intentionally self-inflicted **Injury** or any attempt at intentionally self-inflicted **Injury**[:] [, including, but not limited to, any attempt to restrict the flow of oxygen to the brain for purposes of autoeroticism or auto-erotic asphyxiation;]
- illness, disease, or infections of any kind[, regardless of how contracted]; medical or surgical treatment of illness, disease or infections; or complications following the surgical treatment of illness, disease or infection; [except for **Accidental** ingestion of contaminated foods;]
- [any **Pre-Existing Condition**;]
- cosmetic surgery, except for reconstructive surgery that is **Medically Necessary** due to a **Covered Injury**;
- [hernia of any kind;] [hemorrhoids of any kind;] [Osgood-Schlatter's Disease;] [osteochondritis;] [appendicitis;] [osteomyelitis;] [cardiac disease or conditions;] [pathological fractures;] [congenital weakness;] [detached retina unless caused by a **Covered Injury**;] or [mental disorder or psychological or psychiatric care or treatment whether or not caused by a **Covered Accident**;]
- war, or any act of war, whether declared or undeclared;
- involvement in any type of active military service;
- treatment provided in a governmental **Hospital** unless **You** are legally obligated to pay such damages;
- any **Injury** for which **You** are entitled to benefits pursuant to any Workers' Compensation Law or other similar legislation;
- any **Injury** for which **You** are entitled to recover benefits from a third party;
- [**You** being under the influence of [intoxicants] or [drugs], unless taken under the advice and in accordance with the directions of a **Physician** operating within the scope of his or her authority. [**You** are conclusively deemed to be under the influence of intoxicants if the level of alcohol in **Your** blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether **You** are in fact operating a motor vehicle when the **Injury** occurs. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of **Your** intoxication.];]

- [participation in the commission or attempted commission of [a crime,] [any felony,] [an assault,] [insurrection] or [riot]; [or any **Injury** resulting from a provoked attack;]]
- [a cardiovascular event or stroke caused by exertion prior to or at the same time as an **Accident**;]
- [air travel, except as a fare paying passenger on a scheduled commercial flight;]
- [participation in any of the following activities:

[skydiving]	[hang gliding]	[parachuting]	[parasailing]
[automobile racing or stunts]	[bungee-jumping]	[scuba diving]	[heli-skiing]
[motorcycle racing or stunts]	[endurance tests]	[fire fighting]	[racing]
[acrobatic or stunt flying]	[extreme sport stunts]	[hunting]	
[flight on a rocket-propelled or rocket launched aircraft]			
[or any other extra-hazardous activity;]]			
- [riding in or on, entering into or alighting from, or being struck by a two (2) or three (3)-wheeled motor vehicle or a motor vehicle not designed primarily for use on public streets and highways].

(all bracketed General Exclusions, or sections thereof, are in or out based on plan purchased)

SECTION VII – CLAIMS PROVISIONS

Notice. You or Your beneficiary, or someone on Your behalf, must give Us written notice of the loss within twenty (20) days of such loss. The notice must contain Your name and the Policy Number. To request a claim form, You or Your beneficiary, or someone on Your behalf may contact Us at [866-568-2233]. The notice must be sent to the Claims Department at OneBeacon America Insurance Company, [P.O. Box 1009, Morristown, NJ 07962-1009], or any of Our agents. Notice to Our agents is considered notice to Us.

Claim Forms. We will send the claimant Proof of Loss (claim) forms within fifteen (15) days after We receive notice. If the claimant does not receive the forms in fifteen (15) days after submitting notice, he or she can send Us a detailed written report of the claim and the extent of the loss. We will accept this report as a Proof of Loss if sent within the time fixed below for filing a Proof of Loss. The notice should include Your name, the Policyholder’s name and the Policy number.

Proof of Loss. Written Proof of Loss, acceptable to Us, must be sent within ninety (90) days of the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished at such intervals as We may reasonably require. Failure to furnish Proof of Loss, acceptable to Us, within such time, will neither invalidate nor reduce any claim if it is not reasonably possible to furnish the Proof of Loss, and the proof is provided as soon as reasonably possible. and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. We have a right to investigate the Proof of Loss and any relevant documents which You or Your beneficiary, or someone on Your behalf, will make available to Us upon request.

Time of Payment. We will pay claims for all Covered Losses, other than Covered Losses for which the Policy provides any periodic payment, [within [fifteen (15), thirty (30), forty-five (45)] days] (OR) [immediately upon receipt] of written Proof of Loss that is acceptable to Us.

[Unless an optional periodic payment is stated or chosen, any Covered Loss to be paid in periodic payments will be paid at the end of each [one (1), two (2)] week period. The unpaid balance, which remains when Our liability ends, will then be paid when We receive the proof of Covered Loss that is acceptable to Us.] (in or out based on plan purchased)

Recipient of Payment.

1. Loss of Life. Covered Losses resulting from Your death are paid to Your named beneficiary at the time of death. If there is no beneficiary named or Your named beneficiary predeceases or dies at the same time as You, We will pay the benefit to Your survivors in the following order:
 - a. [Your legally married spouse;] (used only when adults covered)
 - b. [Your child(ren);] (used only when adults covered)
 - c. Your parents;

- d. **Your** brothers and sisters;
 - e. **Your** estate.
2. All Other Claims. Benefits are paid to **You** unless a minor or not able to give a valid release. [**You** or **Your** legal representative may direct in writing that all or part of an **Accident Medical Expense Benefit** be paid directly to the party who furnished the service. **You** or **Your** legal representative may change the direction at any time up to the filing of the Proof of Loss.] (in or out based on plan purchased) If **You** die before all payments due have been made, the amount still payable will be paid to **Your** beneficiary, or if there is no beneficiary designated, as set forth above, then to **Your** estate.

Physical Examination and Autopsy. We have the right to examine **You**, if **Your Injury** is the basis of a claim, when and as often as **We** may reasonably request while the claim is pending. Such examination will be at **Our** expense. **We** may also require an autopsy be performed, unless forbidden by law.

Conditional Claim Payment. If **You** suffer a **Covered Loss(es)** as the result of **Covered Injuries** for which a third party may be liable, **We** will pay the amount of benefits otherwise payable under the **Policy**. However, if **You**, **Your** beneficiary or any other person receives payment from the third party, **You**, **Your** beneficiary or any other person agrees to refund to **Us** the lesser of: (1) the amount actually paid by **Us** for such **Covered Loss(es)**; or (2) an amount equal to the sum actually received from the third party for such **Covered Loss(es)**. If **You**, **Your** beneficiary or any other person does not receive payment from the third party for such **Covered Loss(es)**, **We** reserve the right to subrogate under the Subrogation clause of the **Policy**.

At the time such third party liability is determined and satisfied, this amount will be paid whether determined by settlement, judgment, arbitration or otherwise. This provision will not apply where prohibited by law.

Sunset. In no event will a claim made for losses **You** sustained be considered valid and collectible in accordance with the **Policy** unless full details of such claim are presented to **Us** within three (3) years from the date of the **Accident** which is the basis of such claim.

Right to Recover Overpayments. In addition to any rights of recovery, reimbursement or subrogation provided to **Us** herein, when payments have been made by **Us** with respect to a **Covered Loss** in an amount in excess of the maximum amount of payment necessary to satisfy an obligation under the terms of the **Policy**, **We** will have the right to recover such excess payment, from any person to whom such payments were made. **We** maintain the right to offset the overpayment against other benefits payable to **You** (and **Your** assignee) under the **Policy** to the extent of the overpayment.

[Suit Against Us. No action on the **Policy** may be brought until sixty (60) days after written Proof of Loss has been sent to **Us**. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina, Wisconsin and Alabama) of the date the written Proof of Loss was required to be submitted. If the law of the state where the **You** live makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.] (in or out based on plan purchased)

[Arbitration. Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to **You** or the person claiming to be **Your** beneficiary. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if **You** or the person claiming to be **Your** beneficiary is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the institution of any individual or class action lawsuit brought by **You**, **Your** legal representative, or beneficiary.] (in or out based on plan purchased)

[Subrogation. **We** have the right to recover all payments including future payments, which **We** have made, or will be obligated to pay in the future, to **You**, **Your** beneficiary or any other person from anyone liable for the **Covered Injury**. If **You**, **Your** beneficiary or any other person recovers from anyone liable for the **Covered Injury**, **We** will be reimbursed first from such recovery to the extent of **Our** payments to **You**, **Your** beneficiary or any other person. **You**, **Your** beneficiary or any other person agree to assist **Us** in preserving **Our** rights against those responsible for such loss, including but not limited to, signing subrogation forms supplied by **Us**.] (in or out based on plan purchased)

SECTION VIII – GENERAL PROVISIONS

Beneficiaries. You or Your legal representative has the sole right to name a beneficiary. The beneficiary has no interest in the Policy other than to receive certain payments. You or Your legal representative may change the beneficiary at any time. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to Us.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding \$1,000 may be made, at Our option, to any relative by blood or connection by marriage of the payee, who, in Our opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs

Change or Waiver. A change or waiver of any terms or conditions of the Policy must be issued by Us in writing and signed by one of Our executive officers. No agent has authority to change or waive Policy terms or conditions. A failure to exercise any of Our rights under the Policy will not be deemed as a waiver of such rights in the same or future situations.

Clerical Error. A clerical error or omission, whether by the Policyholder, the Producer, or Us, will not increase or continue Blanket Accident coverage, which otherwise would not be in force. If You or Your legal representative applies for insurance for which You are not eligible, We will only be liable for any premiums paid to Us.

Conformity With Statute. Terms of the Policy that conflict with the laws of the state [where it is delivered] (OR) [of Policyholder's address on the Policy] are amended to conform to such laws.

Assignment of Interest. The Policy is non-assignable.

Incontestability. The validity of the Policy will not be contested, except as to nonpayment of premiums or due to a material fraudulent misstatement in obtaining the insurance.

SECTION IX – GENERAL DEFINITIONS

- **Accident** or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the Policy term.
- **Accident Commencement Period** means the time period, shown on the Schedule, between the date of the Accident which caused the Injury and the date the Loss must occur for death or dismemberment benefits to be payable under the Policy.
- **Aggregate Limit of Liability** means the total benefits We will pay for a Covered Accident or Covered Accidents set forth in the Policy. For purposes of the Aggregate Limit of Liability provision, Covered Accident or Covered Accidents will include a Covered Loss or Covered Losses arising out of a single event or related events or originating cause [occurring within a [one (1)] day period] (in or out based on plan purchased) and includes a resulting Covered Loss or Covered Losses. If the total benefits under the Aggregate Limit of Liability is not enough to pay full benefits to each Insured Person, We will pay each one a reduced benefit based upon the proportion that the Aggregate Limit of Liability bears to the total benefits which would otherwise be paid.
- **Ambulatory Medical Center** means a facility that meets all of the following requirements:
 1. operates under the laws of the state that it is situated in;
 2. has a staff of Physicians and permanent facilities that are equipped and operated primarily for the purpose of providing medical services or performing subject procedures; and
 3. provides continuous Physician and Graduate Registered Nurse (RN) services whenever a patient is in the facility. An Ambulatory Medical Center does not include a Hospital or a Physician's office or a clinic.
- [Combined Single Limit means, with respect to any one Insured Person, the total amount of benefits that are payable under the Policy for or in connection with a Covered Injury sustained as the result of any one

Covered Accident. When the **Combined Single Limit** has been reached, no further benefits will be payable under the **Policy**, with respect to that **Insured Person** for or in connection with an **Injury** sustained as the result of that one **Covered Accident.**] (in or out based on plan purchased)

- **Covered Accident** means an **Accident** that occurs while **You** are participating in a [**Covered Activity**] [or] [**Covered Event**] and results in a **Covered Loss**.
- **Covered Accident Medical Services** means the following services, provided that they are **Medically Necessary**:
 1. treatment by a **Physician**, or a licensed practical nurse or RN;
 2. treatment in a **Hospital** semi-private room and board (or room and board in an intensive care unit), including **Hospital** ancillary services (including but not limited to, use of the operating room or emergency room), or use of an **Ambulatory Medical Center**;
 3. services for **Home Health Care**;
 4. ambulance, including air ambulance, service to or from a **Hospital** for one (1) round trip;
 5. laboratory tests;
 6. radiological procedures;
 7. anesthetics and the administration of anesthetics;
 8. medicines or drugs administered by a **Physician** or that can be obtained only with a **Physician's** written prescription;
 9. repair or replacement of **Sound Natural Teeth** damaged or lost as a result of a **Covered Injury**, up to the **Dental Maximum**, if any shown on the **Schedule**.

Payment for the purchase or maintenance of eyeglasses, contact lenses or hearing aids or the examination for the prescription or fitting thereof shall not be considered a Covered Accidental Medical Expense.

- [**Covered Activity(ies)** means the activity(ies) listed on the **Schedule**.] (in or out based on plan purchased)
- [**Covered Event(s)** means the event(s) listed on the **Schedule**.] (in or out based on plan purchased)
- **Covered Injury** means bodily harm or bodily damage that results from a **Covered Accident**, is independent of all other causes, occurs while **You** are insured under the **Policy**, and results in a **Covered Loss**.
- **Covered Loss** means a loss which meets the requisites of one or more benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.
- **Deductible Amount** means the portion of the **Usual and Customary Charges** for **Medically Necessary Covered Accident Medical Services**, incurred due to **Covered Injuries You** sustained in a **Covered Accident**, which must be met before the **Accident Medical Expense Benefit** will be paid. The **Deductible Amount** is shown on the **Schedule**.
- **Eligible Person** means a person who is described on the **ELIGIBLE PERSONS** section of the **Schedule**.
- **Home Health Care** means nursing care and treatment **You** receive in **Your** home as part of an overall extended treatment plan. To qualify, the extended treatment plan must:
 1. be approved in writing by the attending **Physician**;
 2. be provided by a **Hospital** certified to provide **Home Health** services or by a certified **Home Health Care** agency;
 3. begin within [three (3), five (5), seven (7), ten (10)] days after discharge from a **Hospital**; and
 4. follow a **Hospital** confinement of [three (3), five (5), seven (7)] days or more.

No benefits are payable for **Home Health Care** services provided by:

1. a member of **Your** immediate family; or
 2. a person residing in **Your** home.
- **Hospital** means a facility that: (1) operates under the law of the state that it is situated in; (2) is approved by the Department of Health and Human Services or its successor; (3) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (4) has 24-hour nursing service by graduate registered nurses (RN), on duty or on call; and (5) is supervised by one or more **Physicians**. A **Hospital** does not include: (1) a nursing, convalescent or geriatric unit of a **Hospital** when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or

home for the aged; nor does it include any ward, room, wing or other section of the **Hospital** that is used for such purposes; or (3) any military or veterans **Hospital** or soldiers home or any **Hospital** contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

- **Immediate Family Member** means a person who is related to **You** in any of the following ways: [**Spouse,**] (in or out based on plan purchased) brother-in-law, sister-in-law, [son-in-law, daughter-in-law, mother-in-law, father-in-law,] (in or out based on plan purchased) parent (includes stepparent), brother or sister (includes stepbrother or stepsister), [or child (includes legally adopted or placed for adoption, or stepchild)] (in or out based on plan purchased) or any person residing in **Your** home.
- **Insured Person** means a person who is an **Eligible Person** for whom premium has been paid.
- **Maximum Benefit Period** means, with respect to the **Accident Medical Expense Benefit**, the maximum period for which benefits will be payable for **Covered Accident Medical Services** for or in connection with a single **Accident Medical Expense Covered Loss**. The **Maximum Benefit Period** for the **Accident Medical Expense Benefit** commences on the first date of treatment or service and continues for the period of time shown on the **Schedule**.
- **Medical Commencement Period** means the time period shown on the **Schedule** between the date of the **Accident** that caused the **Covered Injury** and the date that the first **Covered Accident Medical Service** must be incurred for **Accident Medical Expense** benefits to be payable under the **Policy**
- **Medically Necessary** means that a **Covered Accident Medical Service**: (1) is essential for diagnosis, treatment or care of the **Covered Injury** for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a **Physician** and performed under his or her care supervision or order. **Medically Necessary** will not include personal comfort or convenience items.
- [**Other Valid and Collectible Insurance** means any plan providing medical expense benefits for or by reason of dental, physician, nurse, hospital care, treatment or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by: (1) any type of service plan contracts, any health maintenance organization or subscriber contracts, any group or blanket insurance, employee benefit plan or plans arranged through an employer, trustee, union, employee benefit association or professional association; (2) any plan or program created or administered by the national or a state government, or agencies thereof; or (3) any individual insurance plan.] (may be used when plan is Voluntary)
- **Physician** means a practitioner of the healing arts acting within the scope of his or her license who is not: (1) [**You;**] (in or out based on plan purchased) (2) **Your Immediate Family Member**; or (3) a practitioner retained by the **Policyholder**.
- **Policy** means the **Blanket Accident Insurance Policy**.
- **Policyholder** is the group named on the front page of the **Policy**.
- [**Pre-Existing Condition** means a condition for which **You** have sought or received medical advice or treatment during the [three (3), six (6), twelve (12), eighteen (18)] months immediately preceding **Your** effective date of [coverage under the **Policy**] (OR) [a **Covered Injury**].] (in or out based on plan purchased)
- **Principal Sum** means the amount of insurance listed on the **Schedule**. The **Accidental Death and Accidental Dismemberment** benefits are based upon this amount.
- **Schedule** is SECTION I of the **Policy**.
- **Sound Natural Teeth** means natural teeth that are either unaltered or fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.
- **Usual and Customary Charge(s)** means a charge that is made for a **Covered Accident Medical Expense Benefit** that: (1) does not include charges that would not have been made if no insurance existed; (2) is the lesser of the: (a) usual charges for similar services, treatment, supplies, or **Hospital** room and board in the locality where the expense is incurred. (For a **Hospital** stay, the **Usual and Customary Charge** is based upon the expense for a semi-private room and board charge, unless the stay is a **Medically Necessary** stay in an intensive care unit.) or (b) the allowable charge as calculated by any **Other Valid and Collectible Insurance** provider; and (3) with respect to drugs, [[75 - 150%] of the Average Wholesale Price (AWP)] [[75 - 150%] of the generic drug price] [[75 - 150%] of the Average Sales Price (ASP)] will be considered Usual and Customary.

- **We, Us, and Our** refers to OneBeacon America Insurance Company.
- **You, and Your** refers to the **Insured Person**.

In Witness Whereof, We have caused the Policy to be executed and attested.



Dennis R. Smith, Secretary
OneBeacon America Insurance Company



Michael Miller, President & CEO
OneBeacon America Insurance Company



ENDORSEMENT FOR RESIDENTS OF ARKANSAS ONLY

1. The provision entitled Arbitration in **SECTION IX – CLAIMS PROVISIONS** and any reference to “arbitration” elsewhere in this **Policy** are deleted.

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

In Witness Whereof, We have caused this Endorsement to be executed and attested.

A handwritten signature in black ink that reads "Dennis R. Smith".

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

A handwritten signature in black ink that reads "Michael Miller".

Michael Miller, President & CEO
OneBeacon America Insurance Company

SERFF Tracking Number: CLTR-126453073 State: Arkansas
 Filing Company: OneBeacon America Insurance Company State Tracking Number: 44803
 Company Tracking Number: AH 650 BA CW FORM
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness
 Product Name: Blanket Accident
 Project Name/Number: Blanket Accident/AH 650 BA CW FORM

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/12/2010
Comments:			
Attachments:			
	AR Flesh Cert .pdf		
	AR Compliance Cert Reg 19 .pdf		
	AR Guaranty Notice.pdf		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/12/2010
Bypass Reason:	The application to be used with this new program is attached to the forms schedule tab.		
Comments:			
		Item Status:	Status Date:
Satisfied - Item:	Authority to File	Approved-Closed	02/12/2010
Comments:			
Attachment:			
	2010 Filing Authorization Letter.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Amendment Letter	Filed-Closed	04/14/2010
Comments:			
Attachment:			
	AR Amendment Filing Letter 4-14-2010.pdf		

ARKANSAS FLESCH CERTIFICATION

ONE BEACON AMERICA INSURANCE COMPANY
FILING AH 650 BA CW FORM

The Policy, Certificate and related endorsements are scored for the Flesch reading ease test as one unit and the combined score is 52.0.

The forms are printed in not less than 10 point type, one point leaded.

Company Officer's Name Tom Farnley
Officer's Title Assistant Secretary
Date February 01, 2010

TO: Arkansas Commissioner of Insurance

RE: OneBeacon America Insurance Company

RULE AND REGULATION 19 CERTIFICATION

This is to certify that Blanket Accident Policy and Endorsements forms program being filed comply with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

Signed for OneBeacon America Insurance Company by

February 8, 2010 *Keith Firestone*

Date

Signature

Keith Firestone
Typed Name

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION PLAN**

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 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
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 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”). On the next page 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.

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 contract holders, 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 nonaffiliated benefit plan or its trustees).

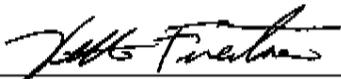
LIMITS ON AMOUNT OF COVERAGE

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 Guaranty 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.



Date: January 11, 2010
To: State Insurance Departments
From: Keith Firestone
Subject: Filing Authority for Coulter & Associates, Inc.

I, Keith Firestone, an officer of OneBeacon America Insurance Company, have authorized Coulter & Associates, Inc., acting as our Contracts Consultants, to file products and correspond with your Department on our Behalf. This Authorization is Effective until December 31, 2010.

Officer Signature: 

Title: Assistant Secretary



Stephanie Young
Senior Compliance Consultant

379 Princeton-Hightstown Rd.
Cranbury, NJ 08512
Phone: 609-443-7540
Fax: 609-443-4103
stephaniey@coulter-and-associates.com

April 14, 2010

Arkansas Insurance Department
Via SERFF

RE: ONEBEACON AMERICA INSURANCE COMPANY
NAIC: 20621 FEIN: 04-2475442
Group Blanket Accident Program

Dear Sir or Madam:

This filing is amended to clarify that the Blanket Accident Program will be marketed to both large and small defined blanket groups.

Sincerely,

Stephanie Young

Stephanie Young
Senior Compliance Consultant