Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Accident Insurance Policy - New Riders	SERFF Tr Num: ZURC-126614667	State: Arkansas
TOI: H03G Group Health - Accidental Death & Dismemberment	SERFF Status: Closed-Approved-Closed	State Tr Num: 45626
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment	Co Tr Num: CW AH 30479	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Patricia Chudik, Carolyn Denk	Disposition Date: 05/12/2010
	Date Submitted: 05/10/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: CW AH 30479 - Accident Insurance Policy - New Riders	Status of Filing in Domicile: Authorized
Project Number: CW AH 30479	Date Approved in Domicile: 04/27/2010
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type:	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association, Other
Filing Status Changed: 05/12/2010	Explanation for Other Group Market Type: Financial Institutions, Creditors, Credit Unions, Trustees and Vendors, etc.
	State Status Changed: 05/12/2010
Deemer Date:	Created By: Patricia Chudik
Submitted By: Carolyn Denk	Corresponding Filing Tracking Number:

Filing Description:

We submit for your review and approval seven new riders for use with the Group Accident Insurance product, recently filed with and authorized by your Department. As indicated in the original filing, the Group Accident Insurance product and these new riders will be marketed to all statutorily eligible groups in your state consisting of two (2) or more

individuals. Eligible groups shall include, but are not limited to: credit union groups; debtor groups; creditor groups; vendor groups; association groups; and financial institutions.

The Group Accident Insurance product and these riders may be marketed through brokers, consultants, third party administrators and sales employees.

The seven riders are new and are not intended to replace any other forms currently in use.

The Group Accident Policy was filed and approved in Arkansas, effective 12/01/2009 under tracking number ZURC-126394542/44163.

Company and Contact

Filing Contact Information

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

Filing Company Information

Zurich American Insurance Company
1400 American Lane
Schaumburg, IL 60102
(847) 605-6000 ext. [Phone]

CoCode: 16535
Group Code: 212
Group Name:
FEIN Number: 36-4233459

State of Domicile: New York
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$400.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	$400.00	05/10/2010	36369029

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2010	05/12/2010

Disposition

Disposition Date: 05/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ZURC-126614667*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*45626*
Company Tracking Number:	*CW AH 30479*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Accident Insurance Policy - New Riders*		
Project Name/Number:	*CW AH 30479 - Accident Insurance Policy - New Riders /CW AH 30479*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanatory Memorandum	Approved-Closed	Yes
Supporting Document	AR Statement of Variables	Approved-Closed	Yes
Supporting Document	U-GMC-103-B AR Summary of Changes	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	[Out of Country] Accident Excess Integrated Medical Expense Benefit	Approved-Closed	Yes
Form	Personal Property Benefit	Approved-Closed	Yes
Form	[Out of Country] Accident Medical Expense Benefit	Approved-Closed	Yes
Form	Critical Illness Coverage	Approved-Closed	Yes
Form	Wellness Benefit	Approved-Closed	Yes
Form	Waiver of Premium Due to Loss of Employment Benefit	Approved-Closed	Yes
Form	No Claim Discount	Approved-Closed	Yes

Form Schedule

Lead Form Number: U-GMC-100-A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/12/2010	U-GMC-103-B AR (04/10)	Application/Enrollment Form	Enrollment Form	Revised	Replaced Form #: U-GMC-103-A AR (08/09) Previous Filing #: ZURC-126394542/44163	53.000	U-GMC-103-B AR - Enrollment Form.pdf
Approved-Closed 05/12/2010	U-GMC-121-A CW (04/10)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	[Out of Country] Accident Excess Integrated Medical Expense Benefit	Initial		49.000	U-GMC-121-A CW - AME XS Integrated.pdf
Approved-Closed 05/12/2010	U-GMC-134-A CW (04/10)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Personal Property Benefit	Initial		53.000	U-GMC-134-A CW - Personal Property Benefit.pdf
Approved-Closed 05/12/2010	U-GMC-138-A CW (04/10)	Policy/Contract/Fraternal Certificate: Amendment, Insert	[Out of Country] Accident Medical Expense Benefit	Initial		49.000	U-GMC-138-A CW - AME Primary.pdf

Approved-Closed 05/12/2010	U-GMC-140-A CW (04/10)	Page, Endorsement or Rider Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Critical Illness Coverage	Initial	50.000	U-GMC-140-A CW - Critical Illness Coverage.pdf
Approved-Closed 05/12/2010	U-GMC-143-A CW (04/10)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Wellness Benefit	Initial	54.000	U-GMC-143-A CW - Wellness Benefit.pdf
Approved-Closed 05/12/2010	U-GMC-144-A CW (04/10)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Waiver of Premium Due to Loss of Employment Benefit	Initial	54.000	U-GMC-144-A CW - Waiver of Premium Due to Loss of Employment Benefit.pdf
Approved-Closed 05/12/2010	U-GMC-145-A CW (04/10)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page,	No Claim Discount	Initial	54.000	U-GMC-145-A CW - No Claim Discount.pdf

SERFF Tracking Number:	*ZURC-126614667*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*45626*
Company Tracking Number:	*CW AH 30479*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Accident Insurance Policy - New Riders*		
Project Name/Number:	*CW AH 30479 - Accident Insurance Policy - New Riders /CW AH 30479*		

Endorseme
nt or Rider

Enrollment Form

Group Accident Insurance

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

DEPENDENT CHILD(REN) INFORMATION (if Enrollee is applying for Dependent coverage)		
Full Legal Name (First, Middle Initial and Last):	Gender: ☐Male ☐ Female	Date of Birth (MM/DD/YYYY):
Full Legal Name (First, Middle Initial and Last):	Gender: ☐Male ☐ Female	Date of Birth (MM/DD/YYYY):

INSURANCE REQUESTED	
Plan Selected (please check each box that applies):	**Principal Sum (coverage amount)**
☐ Enrollee	$
[☐ **Spouse** [or **Domestic Partner**] Only]	[as per the Schedule]
[☐ **Dependent Child(ren)** Only]	[as per the Schedule]
[☐ **Spouse** [or **Domestic Partner**] and **Dependent Child(ren)**]	[as per the Schedule]
[The **Principal Sum** for Covered **Dependents** will be a percentage of the Enrollee's **Principal Sum**.]	
[**Coverage(s) Included**:	**Coverage Amount**
[Accidental Death Coverage]	[as per the Schedule]

[Dismemberment Coverage]	[as per the Schedule]
[Exposure and Disappearance Coverage]	[as per the Schedule]
[Critical Illness Coverage]	[as per the Schedule]
[ ]	[as per the Schedule]]
[**Benefit(s) Included**:	**Benefit Amount**
[[Higher] Education Benefit]	[as per the Schedule]
[Common Carrier Benefit]	[as per the Schedule]
[Common Disaster Benefit]	[as per the Schedule]
[Carjacking Benefit]	[as per the Schedule]
[Felonious Assault Benefit]	[as per the Schedule]
[Identity Theft Resolution Services]	[as per the Schedule]
[Rehabilitation Benefit]	[as per the Schedule]
[Seat Belt[/Air Bag] Benefit]	[as per the Schedule]
[[Out of County] Accident Excess Integrated Medical Expense Benefit]	[as per the Rider]
[[Out of County] Accident Medical Expense Benefit]	[as per the Rider]
[Wellness Benefit]	[as per the Schedule]
[Personal Property Benefit]	[as per the Schedule]
[Waiver of Premium Due to Loss of Employment Benefit]	[as per the Schedule]
[ ]	[as per the Schedule]]

[**CRITICAL ILLNESS COVERAGE QUESTIONNAIRE**	
1. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever been diagnosed with or treated for any of the following (*Oregon residents only*: during the past ten (10) years):	
a. heart attack, angina, high blood pressure, chest pains, disease or disorder of the heart or circulatory system, diabetes?	☐ YES ☐ NO
b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders?	☐ YES ☐ NO
c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder?	☐ YES ☐ NO
d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease?	☐ YES ☐ NO
e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?	☐ YES ☐ NO]
2. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or treated for acquired immune deficiency syndrome (AIDS)?	☐ YES ☐ NO
3. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever been advised of the need for a transplant, been evaluated for a transplant and/or currently on a transplant waiting list?	☐ YES ☐ NO]

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

PREMIUM INFORMATION:	
Annual Premium: $	Frequency of Payment: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly
Method of Payment: ☐ Credit Card ☐ Bank Draft [☐ Direct Bill] The Enrollee must complete a separate authorization form for a Credit Card or Bank Draft payment.	

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

The Enrollee hereby enrolls for Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

It is hereby understood and agreed that:

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

Enrollee's Signature (may be electronic): Date:

[**AGENT INFORMATION**	
Name of Agent:	Agent's State License Number:
Agent's Signature:	[Producer Number:]]

[Out of Country] Accident Excess Integrated Medical Expense Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This rider modifies insurance provided under the Group Accident Policy/Certificate.

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

Accident Medical Expense Schedule		
Benefit	Maximum Benefit per [**Insured][Covered Person]** per **Covered Accident**	Deductible per [**Insured][Covered Person]** per **Covered Accident**
[Accident Medical]	$[10,000]	$[100]
[Benefit Limitations]		
[Accident Dental]	$[1,000]	$[100]
[Pregnancy]	$[1,000]	$[100]
[**Custodial Services**]	$[1,000]	$[100]

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

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

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

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

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

10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
    a. is primarily and customarily used to serve a medical purpose;
    b. can withstand repeated use; and
    c. generally is not useful to a person in the absence of injury.

    No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for [an **Insured**][a **Covered Person]**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

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

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

Hospital means an institution which:

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

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

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

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

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

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

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

Medically Necessary means that the medical service or treatment:

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

[**Medical Repatriation** means transporting [an **Insured**][a **Covered Person]** back to his or principal residence or to the country where he or she was assigned due to the [**Insured][Covered Person]** being injured.]

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

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

EXCLUSIONS:

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

1. [Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.]
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. Any expenses for a **Pre-existing Condition**.
4. **Covered Injury** for which the [**Insured][Covered Person]** is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
5. [Travel [into or within] [outside of] the United States of America.]
6. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
7. Treatment by any person **Related** to the [**Insured][Covered Person]**.
8. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.]
9. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
10. [A hernia.]
11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].

12. [A **Medical Repatriation**.]
13. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
14. Expenses which the [**Insured][Covered Person]** is not legally obligated to pay.
15. [Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.]
16. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment in the underlying bodily condition.]
17. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.]
18. [being legally intoxicated while operating a motor vehicle.
    a. [An **Insured**][A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the **Accident** occurred.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the [**Insured's**][**Covered Person's**] legal intoxication.
19. [being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage].
20. [Treatment of Osgood-Schlatter's Disease].

EXCESS INTEGRATED

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

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

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

[**SUBROGATION**

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

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

Personal Property Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This rider modifies insurance provided under the Group Accident Policy/Certificate.

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

If [an **Insured**] [a **Covered Person**] suffers a **Covered Injury** requiring emergency medical attention by a **Physician** resulting in a **Covered Loss** as a result of a **Covered Accident** and due to that same **Covered Accident** the [**Insured**][**Covered Person**] sustains a total loss or destruction to **Personal Property**, **We** will pay a benefit [after satisfaction of the Deductible per **Covered Accident**] up to the amount shown on the Schedule [provided **We** receive an incident report from a police or security authority].

[We will require valid receipts of replacement goods prior to payment of any benefits.]

Personal Property includes but is not limited to the following items [that are originally issued by a [police][fire][security] department and for which the **Covered Person** is financially responsible to return or replace]: clothing, musical instruments, cameras, jewelry, watches, furs, radios, [uniform, radio, baton, cuffs, protective vest, handgun, helmet, boots, and other items that would typically accompany a [police][security officer][fireman] in his or her daily duties] and other similar items that would accompany a reasonable person. **Personal Property** does not include laptop computers or currency. This benefit does not apply to the destruction of **Personal Property** through normal wear and tear, mechanical breakdown, vermin, or physical abuse or neglect of the **Personal Property** by the [**Insured**][**Covered Person**].

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

[Out of Country] Accident Medical Expense Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This rider modifies insurance provided under the Group Accident Policy/Certificate.

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

Accident Medical Expense Schedule		
Benefit	Maximum Benefit per [**Insured][Covered Person]** per **Covered Accident**	Deductible per [**Insured][Covered Person]** per **Covered Accident**
[Accident Medical]	$[10,000]	$[100]
[Benefit Limitations]		
[Accident Dental]	$[1,000]	$[100]
[Pregnancy]	$[1,000]	$[100]
[**Custodial Services**]	$[1,000]	$[100]

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

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

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

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

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

10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless **Medically Necessary** to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
    a. is primarily and customarily used to serve a medical purpose;
    b. can withstand repeated use; and
    c. generally is not useful to a person in the absence of injury.

    No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses, for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for [an **Insured**][a **Covered Person]**. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen and its administration.

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

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

Hospital means an institution which:

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

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

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

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

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

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

Medically Necessary means that the medical service or treatment:

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

[**Medical Repatriation** means transporting [an **Insured][**a **Covered Person]** back to his or principal residence or to the country where he or she was assigned due to the [**Insured][Covered Person]** being injured.]

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

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

EXCLUSIONS:

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

1. [Cosmetic, plastic or restorative surgery unless **Medically Necessary** for the treatment of the **Covered Injury**.]
2. Any medical expenses related to pregnancy unless **Medically Necessary** for the treatment of the **Covered Injury**.
3. Any expenses for a **Pre-existing Condition.**
4. **Covered Injury** for which the [**Insured**][**Covered Person**] is entitled to benefits under Workers Compensation Benefits, Employer Liability Law, or other similar law.
5. [Travel [into or within] [outside of] the United States of America.]
6. Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals.
7. Treatment by any person **Related** to the [**Insured**][**Covered Person**].
8. [Expenses incurred for dental care, treatment, repair or replacement of sound natural teeth unless **Medically Necessary** for the treatment of the **Covered Injury**.]
9. Expenses incurred for eye examinations, eye glasses, contact lenses or hearing aids or the fitting, repair or replacement of these items unless **Medically Necessary** for the treatment of the **Covered Injury**.
10. [A hernia.]
11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].
12. [A **Medical Repatriation**.]
13. [Expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
14. Expenses which the [**Insured**][**Covered Person**] is not legally obligated to pay.
15. [Expenses for **Custodial Services** or services provided by a private duty nurse unless such expenses are incurred as a result of a **Covered Injury**.]

16. [Expenses related to the repair or replacement of existing artificial limbs, eyes, or other prosthetic appliances, or rental of existing medical equipment unless for the purpose of modifying the item because the **Covered Injury** has caused further impairment in the underlying bodily condition.]
17. [Treatment involving conditions caused by repetitive motion injuries or cumulative trauma and not a result of a **Covered Injury**.]
18. [being legally intoxicated while operating a motor vehicle.
    a. [An **Insured**][A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed intoxicated under the law of the locale wherein the **Accident** occurred.
    b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or other similar items will be considered proof of the [Insured's][Covered Person's] legal intoxication.
19. [being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic or hallucinogen was prescribed by a **Physician** and taken in accordance with the prescribed dosage].
20. [Treatment of Osgood-Schlatter's Disease.]

[**SUBROGATION**

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

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

Critical Illness Coverage

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This Coverage modifies insurance provided under the Group Accident Policy/Certificate.

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

1. Coverage - Under the terms of the Critical Illness Coverage, **We** will pay the [**Insured**][**Covered Person**] the **Coverage Amount** as a coverage payment:
   a. If the [**Insured**][**Covered Person**] is diagnosed by a **Physician** as having a **Covered Condition** and the diagnosis is made while the Coverage is in force;
   b. if the **Covered Condition** is not a **Preexisting Condition**;
   c. if the **Covered Condition** first occurs after the **Waiting Period**; and
   d. if none of the exclusions or limitations described in the Coverage apply.

   If the [**Insured**][**Covered Person**] dies before **We** receive notice of a claim under the **Policy**, no Critical Illness Coverage is payable.

2. **Coverage Amount** - The **Coverage Amount** is that amount shown on the Schedule and will be reduced as described below:
   a. The **Coverage Amount** will be reduced to [50] percent of the **Coverage Amount** when the [**Insured**][**Covered Person**] reaches age [65].
   b. If the **Policy's Principal Sum** is decreased for any other reason, such that the **Coverage Amount** exceeds [50] percent of the **Principal Sum**, such **Coverage Amount** will be reduced to [50] percent of the remaining **Principal Sum**.
   c. [If the sum of the **Coverage Amounts** on this and any other Critical Illness Coverage or Critical Illness Policy issued by us on the life of the [**Insured**][**Covered Person**] exceeds [$250,000], the **Coverage Amount** for each such Coverage and **Policy** will be decreased proportionately such that the sum of the **Coverage Amounts** becomes [$250,000] before any claim is paid. **We** will adjust the premiums for such Coverages and policies and refund to the [**Insured**] the excess of premiums already paid over the premiums that should have been paid for the new **Coverage Amount**, without interest.]

3. **Covered Conditions** - The following are **Covered Conditions**. If a condition is not listed in this subsection, it is not a **Covered Condition** and coverage under this Coverage does not apply.

   [**Cancer/Cancerous** is a malignant neoplasm (including lymphatic and hematological malignancy) characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. To qualify for the **Coverage Amount**, the **Diagnosis** of **Cancer** must be supported by histological evidence of malignancy, must be made by a Pathologist **Physician**, and the **Cancer** must first occur after a [90-day] **Waiting Period**.

   Excluded from coverage are:
   a. Benign tumors or polyps that are histologically described as non-malignant, pre-malignant or non-invasive.
   b. All tumors, benign or malignant, in the presence of HIV infection.
   c. All skin Cancers with the exception of invasive melanoma classified as Clark level II or higher or having a thickness measured in excess of 0.75mm.
   d. Carcinoma in situ (defined as being in position and not extending beyond the focus or level of origin).
   e. All tumors of the prostate, unless having progressed to at least TNM classification T2N0M0 or histologically classified as having a Gleason score greater than 6.
   f. Chronic Lymphocytic Leukemia (CLL) unless Rai Stage 3 or greater.
   g. Papillary microinvasive Cancer of the thyroid, bladder, cervix, or breast.]

   [**Heart Attack (Myocardial Infarction)** means the death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply. To qualify for the **Coverage Amount**, the **Diagnosis** of a **Heart Attack** must be

made by a **Physician** and the **Heart Attack** must first occur after a [30-day] **Waiting Period**. The **Diagnosis** must be supported by all of the following:

a. A history consistent with **Heart Attack**;
b. New electrocardiogram (EKG) changes demonstrating significant Q waves (duration greater than or equal to .04 seconds and a depth greater than or equal to 5 mm) or loss of R waves diagnostic of a **Heart Attack**;
c. Elevation of cardiac enzymes, including CPK-MB and troponin; and
d. If performed, nuclear imaging scan or echocardiogram consistent with **Myocardial Infarction**.

[Excluded from coverage are all other heart disorders, including but not limited to: congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, and all other dysfunctions of the cardiovascular system, unless also accompanied by a **Heart Attack** as defined above.]]

[**Kidney Failure** means the chronic and irreversible failure of both kidneys to excrete metabolites or retain electrolytes. To qualify for the **Coverage Amount**, the **Diagnosis** of **Kidney Failure** must be made by a Nephrological **Physician**. The **Kidney Failure** must require either chronic dialysis or transplantation and must first occur after a [30-day] **Waiting Period**.]

[**Loss of Limb(s)** - The loss of one or more limbs (arms or legs) due to injury. To qualify for the **Coverage Amount**, the **Loss of Limb(s)** must involve complete and permanent severance of one or more limbs through or above the elbow or knee joint. The **Loss of Limb(s)** must be uncorrectable by surgery or any other means. To qualify for the **Coverage Amount**, the **Loss of Limb(s)** must first occur after a [30-day] **Waiting Period**.

[Excluded from coverage is **Loss of Limb(s)** due to a disease process.]]

[Major Organ Transplant means the receipt by transplant of human bone marrow or an entire human heart, kidney, lung, pancreas or liver. To qualify for the **Coverage Amount**, the **Major Organ Transplant** must be performed by a **Physician** and must first occur after a [30-day] **Waiting Period**.]

[**Paralysis** means the loss of motor function due to neurological injury. To qualify for the **Coverage Amount**, the **Diagnosis** of **Paralysis** must be made by a Neurological **Physician**. There must be complete and permanent loss of use of both legs (complete paraplegia or quadriplegia) through neurological trauma or **Accident** to the spinal cord. The **Paralysis** must have been present for a continuous period of at least [90] days. To qualify for the **Coverage Amount**, the **Paralysis** must first occur after a [30-day] **Waiting Period**.]

[Excluded from coverage is **Paralysis** resulting from any neurological disease, including but not limited to, Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS).]]

[**Stroke (Cerebrovascular Accident)** - The sudden loss of neurological function due to an ischemic or hemorrhagic intracranial vascular event. To qualify for the **Coverage Amount**, the **Diagnosis** of **Stroke** must be made by a **Physician** and the **Stroke** must first occur after a [30-day] **Waiting Period**. The **Stroke** must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [30] days and be verified by computed tomography (CT) scan or magnetic resonance imaging (MRI).

[Excluded from coverage are:

a. Neurological symptoms due to transient ischemic attack (TIA);
b. Brain injury resulting from trauma or generalized anoxia (hypoxia); and
c. Vascular disease affecting the eye, optic nerve, or vestibular function.]]

4. **Waiting Period** means the continuous period of time beginning on the later of the Coverage Effective Date or the effective date of any Coverage reinstatement, and ending on the last day of the **Waiting Period** specified for each **Covered Condition**. The [**Insured**][**Covered Person**] must be covered continuously under the Coverage before the **Coverage Amount** may be payable and the **Covered Condition** must first occur after the **Waiting Period**. If the [**Insured's**][**Covered Person's**] **Covered Condition** first occurs prior to or during the **Waiting Period**, no Critical Illness Coverage is payable, the Coverage will terminate, and **We** will refund to the **Insured** all premiums paid for this Coverage without interest. A **Covered Condition** shall be considered to have first occurred when symptoms or laboratory and/or clinical findings that lead to the **Diagnosis** of a **Covered Condition** are first documented in the [**Insured's**][**Covered Person's**] medical records regardless of the date upon which the **Diagnosis** is actually made.

5. [**Preexisting Condition** means a condition for which symptoms existed within [two years] prior to the later of the Coverage Effective Date or the effective date of any Coverage reinstatement. If the [**Insured**][**Covered Person**] is

Diagnosed with a **Covered Condition** that is determined by **Our Physician** at **Our** expense to be a **Preexisting Condition**, no Critical Illness Coverage is payable for that **Covered Condition**.]

6. **Diagnosis/Diagnosed** means the definitive establishment, acceptable to us, of the **Covered Condition** through the use of clinical and/or laboratory findings and subject to the terms and conditions of the Coverage. The **Diagnosis** must be made by a **Physician** who is a board-certified specialist where required under the terms of the Coverage.

7. Payment of the **Coverage Amount** is subject to all of the following conditions:
   a. The sum of the **Coverage Amounts** payable under the Coverage and any other Critical Illness Coverages and Critical Illness policies issued by **Us** on the life of the [**Insured**][**Covered Person**] may not exceed [$250,000].
   b. Only one **Coverage Amount** payment is allowed during the lifetime of the [**Insured**][**Covered Person**], as defined by the terms and conditions of the Coverage.
   c. **We** must receive proof of eligibility that is acceptable to **Us**.
   d. **We** must receive a consent form from all irrevocable beneficiaries and permitted assignees, if any. **We** also reserve the right to require a consent form from the [**Insured**][**Covered Person**] and the **Insured**, their spouse's, other beneficiaries, and any other person, if in our sole discretion, such person's consent is necessary to protect our interests.
   e. This Coverage is not meant to cause involuntary access to proceeds. Therefore, this Coverage will be restricted to a refund of the premiums paid to date for the Coverage without interest if the [**Insured**][**Covered Person**] is:
      i. required by law to use the Coverage to meet the claims of creditors, whether in bankruptcy or otherwise; or
      ii. required by a government entity to use the Coverage in order to apply for, obtain, or otherwise keep a government benefit or entitlement or for any other reason.

8. Exclusions and Limitations
   In addition to any other conditions, exclusions or limitations set forth in the Coverage, no coverage will be provided if the **Covered Condition** is caused by, occurs during or results from:
   a. [Participation in the commission or attempted commission of a felony.]
   b. [Voluntary participation in a riot or insurrection.]
   c. [Refusing certain types of recommended medical treatment, as follows:
      i. [A **Physician** has recommended treatment with angioplasty or coronary artery bypass graft for coronary artery disease, the [**Insured**][**Covered Person**] refuses this treatment, and the [**Insured**][**Covered Person**] suffers a **Heart Attack**;]
      ii. [A **Physician** has recommended treatment for a brain aneurysm or carotid artery stenosis, the [**Insured**][**Covered Person**] refuses treatment, and the [**Insured**][**Covered Person**] suffers a **Stroke**;][or]
      iii. [A **Physician** has recommended a diagnostic biopsy or diagnostic/therapeutic excision of a mass or lesion suspected of being **Cancerous**, the [**Insured**][**Covered Person**] refuses, and the [**Insured**][**Covered Person**] develops **Cancer**.]]

   If the [**Insured**][**Covered Person**] is **Diagnosed** with a **Covered Condition** that **We** determine to be a **Preexisting Condition**, no **Coverage Amount** is payable for that **Covered Condition**. Furthermore, **We** will not pay the **Coverage Amount** for a **Covered Condition** if:
   a. Such **Covered Condition** has not been **Diagnosed** by a **Physician**;
   b. Such **Covered Condition** was not **Diagnosed** until the Coverage had terminated; or
   c. The [**Insured**][**Covered Person**]'s date of birth or age was misstated on the application for the **Policy** and, using the correct date of birth or age, the Coverage would not have become effective or would have terminated prior to **Diagnosis** of a **Covered Condition**.

9. After the **Coverage Amount** is paid, the Coverage will terminate.

10. **We** will provide a statement to the [**Insured**][**Covered Person**], any irrevocable beneficiary, and any permitted assignees, showing the effect of the **Coverage Amount** payment on the **Policy** when the [**Insured**][**Covered Person**] receives payment of the **Coverage Amount**.

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

Wellness Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This rider modifies insurance provided under the Group Accident Policy/Certificate.

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

If after this **Policy** has been in force for [six (6)] months, [an **Insured**][a **Covered Person]** undergoes a **Routine Examination or Other Preventative Tests**, **We** will pay the amount shown on the Schedule regardless of the number of **Covered Persons** or the number of **Routine Examinations or Other Preventative Tests** undergone by a **Covered Person**.

For the purpose of this rider only, **Routine Examinations or Other Preventative Tests** means annual physical examinations, mammograms, pap smears, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSA's), ultrasounds, and blood screening as prescribed by a **Physician**.

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

Waiver of Premium Due to Loss of Employment Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This rider modifies insurance provided under the Group Accident Policy/Certificate.

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

If an **Insured** becomes **Unemployed** while covered under this **Policy**, **We** will waive the premium due from him or her under this **Policy**, provided the **Unemployment** continues for a period greater than [180] consecutive days.

Premium payments must continue for the first [180] days of the continuous **Unemployment**. After the initial [180] day period of continuous **Unemployment**, the **Insured's** premium for this **Policy** will be waived until the earliest of the following:

1. the **Insured** is no longer **Unemployed**;
2. the **Policy** terminates;
3. [60] days expired since the Waiver of Premium was granted by **Us**.
4. [the **Insured** attains age [70]].

For purposes of this rider only, **Unemployed**/**Unemployment** means that the **Insured** was a full time employee within [180] days prior to the request for Waiver of Premium and was involuntarily discharged from that employment and is registered with the appropriate government employment agency.

To apply for this waiver, the **Insured** must notify **Us** in writing of the **Insured's Unemployment** and request a Waiver of Premium Form. The form must be completed by the **Insured** and sent to **Us** as provided under Section XI Reporting & Notice Addresses of the Schedule.

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

No Claim Discount

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

This rider modifies insurance provided under the Group Accident Policy/Certificate.

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

If after the **Certificate** has been in force for [three (3)] years, and no claim has been filed or paid under the coverages for this **Certificate**, [except for Wellness Benefits], **You** are entitled to a **No Claim Discount**.

For the purposes of this rider only, a **No Claim Discount** means a one-time premium reduction of [10%] off the annual premium as stated in the Schedule of the **Certificate**. The **No Claim Discount** will become effective on the next renewal term and will remain in effect until such time as a claim may be filed or paid.

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

Effective Date: _____ Attached to and forming a part of **Policy/Certificate** No. _____

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/12/2010

Comments:

Attachment:

U-GMC Riders 1.1 Certificate of Readability.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/12/2010

Bypass Reason: n/a

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Explanatory Memorandum	Approved-Closed	05/12/2010

Comments:

Attachment:

U-GMC Riders 1.1 Explanatory Memorandum AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	AR Statement of Variables	Approved-Closed	05/12/2010

Comments:

Attachment:

5-10-2010 U-GMC-1001-A AR - Statement of Variables for Arkansas.pdf

		Item Status:	Status Date:
Satisfied - Item:	U-GMC-103-B AR Summary of Changes	Approved-Closed	05/12/2010

SERFF Tracking Number:	*ZURC-126614667*	*State:*	*Arkansas*
Filing Company:	*Zurich American Insurance Company*	*State Tracking Number:*	*45626*
Company Tracking Number:	*CW AH 30479*		
TOI:	*H03G Group Health - Accidental Death & Dismemberment*	*Sub-TOI:*	*H03G.000 Health - Accidental Death & Dismemberment*
Product Name:	*Accident Insurance Policy - New Riders*		
Project Name/Number:	*CW AH 30479 - Accident Insurance Policy - New Riders /CW AH 30479*		

Comments:

Attachment:

U-GMC-103-B AR - Enrollment Form REDLINED.pdf

Certificate of Readability

Zurich American Insurance Company

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

The forms listed below have achieved the following Flesch Scores, when combined with the policy to which they may be attached, using the Flesch Reading Ease software published by Micro Power & Light Co.:

Form Number	Title	Flesch Score
U-GMC-103-B (04/10)	Enrollment Form	53
U-GMC-121-A (04/10)	[Out of Country] Accident Excess Integrated Medical Expense Benefit	49
U-GMC-134-A (04/10)	Personal Property Benefit	53
U-GMC-138-A (04/10)	[Out of Country] Accident Medical Expense Benefit	49
U-GMC-140-A (04/10)	Critical Illness Coverage	50
U-GMC-143-A (04/10)	Wellness Benefit	54
U-GMC-144-A (04/10)	Waiver of Premium Due to Loss of Employment Benefit	54
U-GMC-145-A (04/10)	No Claim Discount	54

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

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

Signature: Lisa Plante

Officer: Lisa Plante

Title: Vice President, Accident & Health

Date: April 23, 2010

Zurich American Insurance Company

EXPLANATORY MEMORANDUM
Group Accident Insurance Policy Riders
Company Filing Number – CW AH 30479

Attached for your review are 7 new riders for which we are seeking your approval to use with the Group Accident Insurance product recently filed with and authorized by your Department. As previously indicated, the Group Accident Insurance product and these new riders will be marketed to all statutorily eligible groups in your state consisting of two (2) or more individuals. Eligible groups shall include, but are not limited to: credit union groups; debtor groups; creditor groups; vendor groups; association groups; and financial institutions.

The Group Accident Insurance product and these riders may be marketed through brokers, consultants, third party administrators and sales employees.

The 7 riders are new and are not intended to replace any other forms currently in use.

The Group Accident Insurance product provides specified benefits for an accidental injury or death. Additional benefits are offered by way of riders. The forms are being filed concurrently in our domiciliary state of New York.

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

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

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

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

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

Statement of Variables for Arkansas

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

Each bracketed benefit or provision will be in or out (in if needed, otherwise omitted). Each bracketed phrase will be in or out. In each instance, the Policy Schedule will be amended to reflect the limits shown for the Benefit.

ENROLLMENT FORM – U-GMC-103-B AR (04/10)

POLICYHOLDER INFORMATION [Master Policy Number:]	This will be in or out.
ENROLLEE INFORMATION [Certificate Number (assigned by the Company):]	This will be in or out.
INSURANCE REQUESTED **Plan Selected** **Principal Sum** [☐ **Spouse** [or **Domestic Partner**] Only] [as per the Schedule] [☐ **Dependent Child(ren)** Only] [as per the Schedule] [☐ **Spouse** [or **Domestic Partner**] and **Dependent Child(ren)**] [as per the Schedule]	 This will be in or out. This will be in or out. This will be in or out.
[The **Principal Sum** for Covered **Dependents** will be a percentage of the Enrollee's **Principal Sum**.]	This will be in or out.
[**Coverage(s) Included**: **Coverage Amount** [Accidental Death Coverage] [as per the Schedule] [Dismemberment Coverage] [as per the Schedule] [Exposure and Disappearance Coverage] [as per the Schedule] [Critical Illness Coverage] [as per the Schedule] [ ] [as per the Schedule]]	This entire section will be in or out. If in: Any combination of Coverages may be in or out; Additional Coverages and Coverage Amounts may be included as filed and approved by the State.
[**Benefit(s) Included**: **Benefit Amount** [[Higher] Education Benefit] [as per the Schedule] [Common Carrier Benefit] [as per the Schedule] [Common Disaster Benefit] [as per the Schedule] [Carjacking Benefit] [as per the Schedule] [Felonious Assault Benefit] [as per the Schedule] [Identity Theft Resolution Services] [as per the Schedule] [Rehabilitation Benefit] [as per the Schedule] [Seat Belt[/Air Bag] Benefit] [as per the Schedule] [[Out of County] Accident Excess Integrated Medical Expense Benefit] [as per the Rider] [[Out of County] Accident Medical Expense Benefit] [as per the Rider] [Wellness Benefit] [as per the Schedule] [Personal Property Benefit] [as per the Schedule] [Waiver of Premium Due to Loss of Employment Benefit] [as per the Schedule] [ ] [as per the Schedule]	This entire section will be in or out. If in: Any combination of Benefit(s) may be in or out; Additional Benefit(s) and Benefit Amounts may be

	included as filed and approved by the State.
[**CRITICAL ILLNESS COVERAGE QUESTIONNAIRE** 1. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever been diagnosed with or treated for any of the following (*Oregon residents only*: during the past ten (10) years): a. heart attack, angina, high blood pressure, chest pains, disease or disorder of the heart or circulatory system, diabetes? b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders? c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder? d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease? e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?] 2. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or treated for acquired immune deficiency syndrome (AIDS)? 3. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever been advised of the need for a transplant, been evaluated for a transplant and/or currently on a transplant waiting list?	This will be in if the Critical Illness Rider is selected as a coverage option. Otherwise, it will be omitted. If in: This will be in or out.

[OUT OF COUNTRY] ACCIDENT EXCESS INTEGRATED MEDIAL EXPENSE BENEFIT – U-GMC-121-A CW (04/10)

[Out of Country] Accident Excess Integrated Medical Expense Benefit	[Out of Country] This will be in or out.
The **Policy** Schedule will be amended to include the following limits for this Benefit:	Each Benefit may be in or out. If in, the ranges will be as follows:
Benefit / Maximum Benefit / Deductible	
[Accident Medical] [$10,000] [$100]	[$1,000 to $500,000] [$0 to $5,000]
[Benefit Limitations] [$100,000] [$100]	[$100 to $10,000] [$0 to $5,000]
[Accident Dental] [$1,000] [$100]	[$100 to $10,000] [$0 to $5,000]
[Pregnancy] [$1,000] [$100]	[$100 to $10,000] [$0 to $5,000]
[Custodial Services] [$1,000] [$100]	[$100 to $10,000] [$0 to $5,000]
We will pay the [**Usual and Customary**] expenses for **Medically Necessary Covered Medical Service(s)** incurred by the [**Insured][Covered Person]** resulting from a **Covered Accident**, up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:	[**Usual and Customary**] This will be in or out.
the first treatment or service occurs within [ninety (90)] days of the **Covered Injury**; and	The range will be thirty (30) to 365 days.
the medical expenses are incurred within [fifty-two (52)] weeks of the **Covered Injury**; and	The range will be four (4) weeks to 104 weeks.
Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.	[twenty-four (24)] The range will be 24 to 72.
Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12] visits.	[one (1)] the range will be 1-3 [twelve [12] The range will be 6 to 18.
Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].	[excluding air ambulance)] This will be in or out.
Hospital Confined means admission to a **Hospital** as an inpatient for [at least 24 consecutive hours] by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to the [**Insured][Covered Person]** is not a hospital confinement under this rider unless there is no charge because the **Hospital** is a United States government facility.	This will be in or out.
[**Medical Repatriation** means transporting [an **Insured**][a **Covered Person]** back to his or principal residence or to the country where he or she was assigned due to the [**Insured][Covered Person]** being injured.]	[Medical Repatriation …] This will be in or out.
Pre-existing Condition means a condition for which [an **Insured**][the **Covered Person**] received any diagnosis,	

medical advice or treatment or had taken any prescription medicines during the [six (6)] months immediately preceding the **Covered Loss**.	[six (6)] The range will be 1 month to twenty-four months.
[**Usual and Customary Expense(s)** means an amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.]	[**Usual and Customary Expense(s)…]** This will be in or out. [and (3) does not exceed the cost of a generic drug…] This will be in or out. [seventy-five percent (75%)] The range will be 25% to 100%.
EXCLUSIONS: Exclusions 1.; 5.; 8.; 10.; 11.; 12.; 15.; 16.; 17.; 18.; 19.; 20.;	Each Exclusion will be in or out.
5. [Travel [into or within] [outside of] the United States of America.]	5. If in, [into or within] [outside of] will be in or out.
11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].	11. If in, [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures] will be in or out.
EXCESS INTEGRATED If no **In Force Policy** exists, this **Policy** will pay benefits on a primary basis [and a deductible [$500] will apply to such benefit].	This will be in or out. If in, the range will be [$100 to $1,000]
[**SUBROGATION**…]	**SUBROGATION**. This will be in or out.

PERSONAL PROPERTY BENEFIT – U-GMC-134-A CW (04/10)

The **Policy** Schedule will be amended to include the following limits for this Benefit: [$5,000]	If in, the Benefit limits range will be [$500 to $5,000].
If [an **Insured**] [a **Covered Person**] suffers a **Covered Injury** requiring emergency medical attention by a **Physician** resulting in a **Covered Loss** as a result of a **Covered Accident** and due to that same **Covered Accident** the [**Insured**][**Covered Person**] sustains a total loss or destruction to **Personal Property**, **We** will pay a benefit [after satisfaction of the Deductible per **Covered Accident**] up to the amount shown on the Schedule [provided **We** receive an incident report from a police or security authority].	[after satisfaction of the Deductible per **Covered Accident**] This will be in or out.
[We will require valid receipts of replacement goods prior to payment of any benefits.]	This will be in or out.
Personal Property includes but is not limited to the following items [that are originally issued by a [police][fire][security] department and for which the **Covered Person** is financially responsible to return or replace]: clothing, musical instruments, cameras, jewelry, watches, furs, radios, [uniform, radio, baton, cuffs, protective vest, handgun, helmet, boots, and other similar items that would typically accompany a [[police][security officer][fireman] in his or her daily duties] and other items that would accompany a reasonable person.	This will be in or out. If in, [police][fire][security] will be in or out. [uniform, radio, baton, cuffs, protective vest, handgun, helmet, boots, and other similar items that would typically accompany a [police][security officer][fireman] in his or her daily duties] This will be in or out.

[Out of Country] The **Policy** Schedule will be amended to include the following limits for this Benefit:	This will be in or out.
Benefit / Maximum Benefit / Deductible [Accident Medical] [$10,000] [$100]	These will be in or out. The ranges will be as follows: [$1,000 to $500,000] [$0 to $5,000]
[Benefit Limitations] [$100,000] [$100]	[$100 to $10,000] [$0 to $5,000]
[Accident Dental] [$1,000] [$100]	[$100 to $10,000] [$0 to $5,000]
[Pregnancy] [$1,000] [$100]	[$100 to $10,000] [$0 to $5,000]
[Custodial Services] [$1,000] [$100]	[$100 to $10,000] [$0 to $5,000]
We will pay the [**Usual and Customary**] expenses for **Medically Necessary Covered Medical Service(s)** incurred by the [**Insured][Covered Person]** resulting from a **Covered Accident**, up to the Maximum Benefit shown on the Schedule. Coverage is provided in excess of the deductible shown in the above Accident Medical Expense Schedule provided that:	[**Usual and Customary**] This will be in or out.
1. the first treatment or service occurs within [ninety (90)] days of the **Covered Injury** ; and	The range will be thirty (30) to 365 days.
2. the medical expenses are incurred within [fifty-two (52)] weeks of the **Covered Injury.**	The range will be four (4) weeks to 104 weeks.
Covered Medical Service(s) means any of the following services:	
Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours of an **Accident** and including the attending **Physician's** charges, X-rays, laboratory procedures, use of the emergency room and supplies.	[twenty-four (24)] the range will be 24 to 72
Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy.	[one (1)] the range will be 1-3 [twelve [12] the range will be 6 to 18.
13. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].	[(excluding air ambulance)] This will be in or out.
[Custodial Services means non-medical care, **including**, but l not limited to, services:	**[Custodial Services**…] This will be in or out.
[**Medical Repatriation** means transporting [an **Insured][**a **Covered Person]** back to his or principal residence or to the country where he or she was assigned due to the [**Insured][Covered Person]** being injured.]	[Medical Repatriation …] This will be in or out.
[**Usual and Customary Expense(s)** means an	[**Usual and Customary Expense(s)**…] This will be in

amount(s) that: (1) does not exceed the usual cost for similar treatment, services or supplies in the locality in which it is incurred; or for a **Hospital** room and board charge other than for stay in an intensive care unit, does not exceed the **Hospital's** most common charge for semi-private room and board [or the fee set by the workers' compensation insurance fee schedule, if applicable]; and (2) does not include charges that would not have been made if no insurance existed [and (3) does not exceed the cost of a generic drug, if available. **We** will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.]	or out. This will be in or out. [and (3) does not exceed the cost of a generic drug…] This will be in or out. [seventy-five percent (75%)] The range will be 25% to 100%.
EXCLUSIONS: Exclusions 1.; 5.; 8.; 10.; 11.; 12.; 15.; 16.; 17.; 18.; 19.; 20.;	Each Exclusion will be in or out.
5. [Travel [into or within] [outside of] the United States of America.]	5. If in, [into or within] [outside of] will be in or out.
11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].	11. If in, [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures] will be in or out.
[**SUBROGATION** **We** have the right to recover from any third party all payments including future payments, which **We** have made to the [**Insured][Covered Person]** or on behalf of the **Insured's Spouse or Domestic Partner**, **Dependent Child(ren)**, heirs, guardians or executors or will be obligated to pay in the future to the **Insured**. If the [**Insured][Covered Person]** recovers from any third party, **We** will be reimbursed first from such recovery to the extent of **Our** payments to or on behalf of the [**Insured][Covered Person]**. The [**Insured][Covered Person]** agrees to assist **Us** in preserving its rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]	**SUBROGATION**. This will be in or out.

The **Policy** Schedule will be amended to include the following limits for this Benefit:	
2. **Coverage Amount** - The **Coverage Amount** is that amount shown on the Schedule and will be reduced as described below:	
a. The **Coverage Amount** will be reduced to [50] percent of the **Coverage Amount** when the [**Insured**][**Covered Person**] reaches age [65].	The range will be 5% to 100% of the **Coverage Amount**. The range will be from age 50 to 85.
b. If the **Policy's Principal Sum** is decreased for any other reason, such that the **Coverage Amount** exceeds [50] percent of the **Principal Sum**, such **Coverage Amount** will be reduced to [50] percent of the remaining **Principal Sum**.	The range will be 5% to 100%. The range will be 5% to 100%.
[c. If the sum of the **Coverage Amounts** on this and any other Critical Illness Coverage or Critical Illness Policy issued by us on the life of the [**Insured**][**Covered Person**] exceeds [$250,000], the **Coverage Amount** for each such Coverage and **Policy** will be decreased proportionately such that the sum of the **Coverage Amounts** becomes [$250,000] before any claim is paid. **We** will adjust the premiums for such Coverages and policies and refund to the [**Insured**] the excess of premiums already paid over the premiums that should have been paid for the new **Coverage Amount**, without interest.]	This will be in or out. If in: The range will be $1,000 to $1,000,000. The range will be $1,000 to $1,000,000.
[Cancer/Cancerous is a malignant neoplasm (including lymphatic and hematological malignancy) characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. To qualify for the **Coverage Amount**, the **Diagnosis** of **Cancer** must be supported by histological evidence of malignancy, must be made by a Pathologist **Physician**, and the **Cancer** must first occur after a [90-day] **Waiting Period**. Excluded from coverage are: a. Benign tumors or polyps that are histologically described as non-malignant, pre-malignant or non-invasive. b. All tumors, benign or malignant, in the presence of HIV infection. c. All skin Cancers with the exception of invasive melanoma classified as Clark level II or higher or having a thickness measured in excess of 0.75mm. d. Carcinoma in situ (defined as being in position and not extending beyond the focus or level of origin). e. All tumors of the prostate, unless having progressed to at least TNM classification T2N0M0 or histologically classified as having a Gleason score greater than 6. f. Chronic Lymphocytic Leukemia (CLL) unless Rai Stage 3 or greater. g. Papillary microinvasive Cancer of the thyroid, bladder, cervix, or breast.]	This will be in or out. If in: The range will be 10 to 180 days.
[**Heart Attack (Myocardial Infarction)** means the death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply. To qualify for the **Coverage**	This will be in or out. If in,:

Amount, the **Diagnosis** of a **Heart Attack** must be made by a **Physician** and the **Heart Attack** must first occur after a [30-day] **Waiting Period**. The **Diagnosis** must be supported by all of the following: a. A history consistent with **Heart Attack**; b. New electrocardiogram (EKG) changes demonstrating significant Q waves (duration greater than or equal to .04 seconds and a depth greater than or equal to 5 mm) or loss of R waves diagnostic of a **Heart Attack**; c. Elevation of cardiac enzymes, including CPK-MB and troponin; and d. If performed, nuclear imaging scan or echocardiogram consistent with **Myocardial Infarction**.	The range will be 10 to 180 days.
[Excluded from coverage are: All other heart disorders, including but not limited to: congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, and all other dysfunctions of the cardiovascular system, unless also accompanied by a **Heart Attack** as defined above.]]	This will be in or out.
[**Kidney Failure** means the chronic and irreversible failure of both kidneys to excrete metabolites or retain electrolytes. To qualify for the **Coverage Amount**, the **Diagnosis** of **Kidney Failure** must be made by a Nephrological **Physician**. The **Kidney Failure** must require either chronic dialysis or transplantation and must first occur after a [30-day] **Waiting Period**.]	This will be in or out. If in: The range will be 5 to 180 days.
[**Loss of Limb(s)** - The loss of one or more limbs (arms or legs) due to injury. To qualify for the **Coverage Amount**, the **Loss of Limb(s)** must involve complete and permanent severance of one or more limbs through or above the elbow or knee joint. The **Loss of Limb(s)** must be uncorrectable by surgery or any other means.	This will be in or out. If in:
[Excluded from coverage is: **Loss of Limb(s)** due to a disease process.]]	This will be in or out.
[Major Organ Transplant means the receipt by transplant of human bone marrow or an entire human heart, kidney, lung, pancreas or liver. To qualify for the **Coverage Amount**, the **Major Organ Transplant** must be performed by a **Physician** and must first occur after a [30-day] **Waiting Period**.]	This will be in or out. If in: The range will be 10 to 180 days.
[Paralysis means the loss of motor function due to neurological injury. The **Paralysis** must have been present for a continuous period of at least [90] days.	This will be in or out. If in: The range will be 10 to 180 days.
[Excluded from coverage is: **Paralysis** resulting from any neurological disease, including but not limited to, Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS).]]	This will be in or out.
[**Stroke (Cerebrovascular Accident)** - The sudden loss of neurological function due to an ischemic or hemorrhagic intracranial vascular event. To qualify for the **Coverage Amount**, the **Diagnosis** of **Stroke** must be made by a	This will be in or out. If in:

Physician and the **Stroke** must first occur after a [30-day] **Waiting Period**. The **Stroke** must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [30] days and be verified by computed tomography (CT) scan or magnetic resonance imaging (MRI). [Excluded from coverage are: a. Neurological symptoms due to transient ischemic attack (TIA); b. Brain injury resulting from trauma or generalized anoxia (hypoxia); and c. Vascular disease affecting the eye, optic nerve, or vestibular function.]]	
7. Payment of the **Coverage Amount** is subject to all of the following conditions: a. The sum of the **Coverage Amounts** payable under the Coverage and any other Critical Illness Coverages and Critical Illness policies issued by **Us** on the life of the [**Insured**][**Covered Person**] may not exceed [$250,000].	The range will be $1,000 to $1,000,000.
8. Exclusions and Limitations [a; b; c, 1,2,3]	Exclusions: These will be in or out.

WELLNESS BENEFIT - U-GMC-143-A CW (04/10)

The **Policy** Schedule will be amended to include the following limits for this Benefit: $50 It is hereby understood and agreed that the following changes are made and incorporated into the **Policy/Certificate**:	
If after this **Policy** has been in force for [six (6)] months, [an **Insured**][a **Covered Person]** undergoes a **Routine Examination or Other Preventative Tests**, **We** will pay the amount shown on the Schedule regardless of the number of **Covered Persons** or the number of **Routine Examinations or Other Preventative Tests** undergone by a **Covered Person.**	The range will be 1 to 6 months.

WAIVER OF PREMIUM DUE TO UNEMPLOYMENT - U-GMC-144-A CW (04/10)

The **Policy** Schedule will be amended to include the following Benefit.	
If an **Insured** becomes **Unemployed** while covered under this **Policy**, **We** will waive the premium due from him or her under this **Policy,** provided the **Unemployment** continues for a period greater than [180] consecutive days.	The range will be 90 to 180 days.
Premium payments must continue for the first [180] days of the continuous **Unemployment**. After the initial [180] day period of continuous **Unemployment**, the **Insured's** premium for this **Policy** will be waived until the earliest of the following:	The range will be 90 to 180 days.
1. the **Insured** is no longer **Unemployed**;	The range will be 90 to 180 days.
2. the **Policy** terminates;	
3. [60] days expired since the Waiver of Premium was granted by **Us**.	3. The range will be 30 to 180 days.
4. [the **Insured** attains age [70]].	4. This will be in or out. If in, the range will be age 50 to 85.
For purposes of this rider only, **Unemployed**/**Unemployment** means that the **Insured** was a full time employee within [180] days prior to the request for Waiver of Premium and was involuntarily discharged from that employment and is registered with the appropriate government employment agency.	The range will be 90 to 180 days.

NO CLAIM DISCOUNT – U-GMC-145-A CW (04/10)

The **Policy** Schedule will be amended to include the following Benefit.	The limit amount on the Schedule will have a range of 1% to 10%.
If after the **Certificate** has been in force for [three (3)] years, and no claim has been filed or paid under the coverages for this **Certificate**, [except for Wellness Benefits,] **You** are entitled to a **No Claim Discount.**	The range will be 1 to 5 years. This will be in or out.
For the purpose of this rider only, a **No Claim Discount** means a one-time premium reduction of [10%] off the annual premium as stated in the Schedule of the **Certificate**. The **No Claim Discount** will become effective on the next renewal term and will remain in effect until such time as a claim may be filed or paid.	The range will be 1% to 10%.

Enrollment Form

Group Accident Insurance

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION

Name of **Policyholder**: [Master Policy Number:]

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ENROLLEE INFORMATION

Full Legal Name (First, Middle Initial and Last): Last 4 Digits of SSN: XXX-XX-

Street Address: City: State: Zip Code:

Mailing Address (if different from above): City: State: Zip Code:

Date of Birth (MM/DD/YYYY): Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married [☐ Domestic Partner]

Email Address: Home Phone: - - Work Phone: - - Cell Phone: - -

Requested Effective Date (MM/DD/YYYY): [Certificate Number (assigned by the Company):]

SPOUSE [or DOMESTIC PARTNER] INFORMATION (if Enrollee is applying for Dependent coverage)

Full Legal Name (First, Middle Initial and Last): Home Phone: - -

Street Address (if different than Enrollee's): City: State: Zip Code:

Date of Birth (MM/DD/YYYY): Gender: ☐ Male ☐ Female

DEPENDENT CHILD(REN) INFORMATION (if Enrollee is applying for Dependent coverage)

Full Legal Name (First, Middle Initial and Last): Gender: ☐Male ☐ Female Date of Birth (MM/DD/YYYY):

Full Legal Name (First, Middle Initial and Last): Gender: ☐Male ☐ Female Date of Birth (MM/DD/YYYY):

INSURANCE REQUESTED

Plan Selected (please check each box that applies):	**Principal Sum (coverage amount)**
☐ Enrollee	$
[☐ **Spouse** [or **Domestic Partner**] Only]	[as per the Schedule]
[☐ **Dependent Child(ren)** Only]	[as per the Schedule]
[☐ **Spouse** [or **Domestic Partner**] and **Dependent Child(ren)**]	[as per the Schedule]

[The **Principal Sum** for Covered **Dependents** will be a percentage of the Enrollee's **Principal Sum**.]

[**Coverage(s) Included**:	**Coverage Amount**
[Accidental Death Coverage]	[as per the Schedule]
[Dismemberment Coverage]	[as per the Schedule]
[Exposure and Disappearance Coverage]	[as per the Schedule]
[Critical Illness Coverage]	[as per the Schedule]

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[ ]	[as per the Schedule]]

[**Benefit(s) Included**:	**Benefit Amount**
[[Higher] Education Benefit]	[as per the Schedule]
[Common Carrier Benefit]	[as per the Schedule]
[Common Disaster Benefit]	[as per the Schedule]
[Carjacking Benefit]	[as per the Schedule]
[Felonious Assault Benefit]	[as per the Schedule]
[Identity Theft Resolution Services]	[as per the Schedule]
[Rehabilitation Benefit]	[as per the Schedule]
[Seat Belt[/Air Bag] Benefit]	[as per the Schedule]
[[Out of County] Accident Excess Integrated Medical Expense Benefit]	[as per the Rider]
[[Out of County] Accident Medical Expense Benefit]	[as per the Rider]
[Wellness Benefit]	[as per the Schedule]
[Personal Property Benefit]	[as per the Schedule]
[Waiver of Premium Due to Loss of Employment Benefit]	[as per the Schedule]
[ ]	[as per the Schedule]]

[**CRITICAL ILLNESS COVERAGE QUESTIONNAIRE**	
1. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever been diagnosed with or treated for any of the following (*Oregon residents only*: during the past ten (10) years):	
a. heart attack, angina, high blood pressure, chest pains, disease or disorder of the heart or circulatory system, diabetes?	☐ YES ☐ NO
b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders?	☐ YES ☐ NO
c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder?	☐ YES ☐ NO
d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease?	☐ YES ☐ NO
e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?	☐ YES ☐ NO]
2. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or treated for acquired immune deficiency syndrome (AIDS)?	☐ YES ☐ NO
3. Has the Enrollee [, **Spouse** [or **Domestic Partner**]] [, or **Dependent Child(ren)**] ever been advised of the need for a transplant, been evaluated for a transplant and/or currently on a transplant waiting list?	☐ YES ☐ NO]

BENEFICIARY DESIGNATION

Primary Beneficiary:

Full Legal Name (First, Middle Initial and Last): Relationship: % Share:

Full Legal Name (First, Middle Initial and Last): Relationship: % Share:

Contingent Beneficiary:

Full Legal Name (First, Middle Initial and Last): Relationship: % Share:

PREMIUM INFORMATION:

Annual Premium:
$

Frequency of Payment:
☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

Method of Payment: ☐ Credit Card ☐ Bank Draft [☐ Direct Bill]

The Enrollee must complete a separate authorization form for a Credit Card or Bank Draft payment.

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

The Enrollee hereby enrolls for Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided, at Zurich American Insurance Company's sole discretion, in reliance upon the truth of such information.

It is hereby understood and agreed that:

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

Enrollee's Signature (may be electronic): Date:

[**AGENT INFORMATION**

Name of Agent: Agent's State License Number:

Agent's Signature: [Producer Number:]]

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