

SERFF Tracking Number: ZURC-127626045 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 49957
Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Additional Riders for Accident Insurance Policy SERFF Tr Num: ZURC-127626045 State: Arkansas

TOI: H03I Individual Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved State Tr Num: 49957

Sub-TOI: H03I.000 Health - Accidental Death & Co Tr Num: CW AH 33365 State Status: Waiting Industry Response

Filing Type: Form/Rate

Author: Karen Falbo

Date Submitted: 10/06/2011

Reviewer(s): Donna Lambert

Disposition Date: 11/22/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 12/22/2011

State Filing Description:

General Information

Project Name: Additional Riders for Accident Insurance Policy

Project Number: CW AH 33365

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Karen Falbo

Filing Description:

Attached for your review are new forms for which we are seeking your approval to use with the Individual Accident Insurance product previously approved by your Department on 2/10/2010 in State Tracking Number: 44259.

All forms are new except Application U-IMC-101-B replaces U-IMC-101-A (the application was revised to add these additional riders).

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 09/14/2011

Domicile Status Comments: NY is the Company's state of domicile

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/22/2011

State Status Changed: 10/17/2011

Created By: Karen Falbo

Corresponding Filing Tracking Number:

SERFF Tracking Number: ZURC-127626045 State: Arkansas
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Company and Contact

Filing Contact Information

Karen Falbo, Product Analyst karen.falbo@zurichna.com
 1400 American Lane 847-605-7545 [Phone]
 Schaumburg, IL 60196 847-605-7768 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$1,000.00
 Retaliatory? No
 Fee Explanation: \$50 per form (19) = \$950
 \$50 for rates
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$1,000.00	10/06/2011	52531903

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/22/2011	11/22/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	10/17/2011	10/17/2011	Karen Falbo	11/17/2011	11/17/2011

SERFF Tracking Number: ZURC-127626045 State: Arkansas
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Disposition

Disposition Date: 11/22/2011

Implementation Date: 12/22/2011

Status: Approved

Comment:

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

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Explanatory	Approved	Yes
Supporting Document	Statement of Variables	Approved	Yes
Supporting Document	11-17-11 response - redlined forms	Approved	Yes
Form	Application Accident Insurance	Approved	Yes
Form	Accident [Weekly] Indemnity Benefit	Approved	Yes
Form	Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children	Approved	Yes
Form	[Out of Country] Accident Excess Integrated Medical Expense Benefit	Approved	Yes
Form	[Out of Country] Accident Excess Corridor Medical Expense Benefit	Approved	Yes
Form	Catastrophe Cash Benefit	Approved	Yes
Form	Coma Benefit	Approved	Yes
Form	Emergency Treatment Benefit	Approved	Yes
Form	Funeral Expense Benefit	Approved	Yes
Form (revised)	In-Hospital Indemnity Benefit	Approved	Yes
Form	In-Hospital Indemnity Benefit	Replaced	Yes
Form	Personal Property Benefit	Approved	Yes
Form	Terrorism Benefit	Approved	Yes
Form	Travel Assistance Coverage	Approved	Yes
Form (revised)	[Out of Country] Accident Medical Expense Benefit	Approved	Yes
Form	[Out of Country] Accident Medical Expense Benefit	Replaced	Yes
Form (revised)	Critical Illness Coverage	Approved	Yes
Form	Critical Illness Coverage	Replaced	Yes
Form	Wellness Benefit	Approved	Yes
Form	Waiver of Premium Due to Loss of Employment Benefit	Approved	Yes
Form	No Claim Discount	Approved	Yes

<i>SERFF Tracking Number:</i>	<i>ZURC-127626045</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>49957</i>
<i>Company Tracking Number:</i>	<i>CW AH 33365</i>		
<i>TOI:</i>	<i>H03I Individual Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03I.000 Health - Accidental Death & Dismemberment</i>
<i>Product Name:</i>	<i>Additional Riders for Accident Insurance Policy</i>		
<i>Project Name/Number:</i>	<i>Additional Riders for Accident Insurance Policy/CW AH 33365</i>		
Form	Accidental Dismemberment [and Covered Approved Loss of Use] [and Plegia] Coverage		Yes
Rate	Exhibit I (Premiums)	Approved	Yes

SERFF Tracking Number: ZURC-127626045 State: Arkansas
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Dismemberment Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/17/2011
Submitted Date 10/17/2011
Respond By Date 11/17/2011

Dear Karen Falbo,

This will acknowledge receipt of the captioned filing.

Objection 1

- Catastrophe Cash Benefit, U-IMC-125-A AR (05/11) (Form)
- Coma Benefit, U-IMC-127-A AR (05/11) (Form)

Comment: If an insured has the Catastrophe rider and the Coma rider, will benefits from both riders be paid if the insured becomes comatose?

Objection 2

- Terrorism Benefit, U-IMC-136-A CW (05/11) (Form)

Comment: Our Department will not approve exclusions for terrorism or other similar language in life or accident and health contracts; therefore, acts of terrorism are automatically covered by the policy to which this rider is intended to be attached. Please note that exclusion 10 in the policy does not apply to the release of nuclear energy or radiation if it occurs as an act of terrorism.

Please remove this rider.

Objection 3

- In-Hospital Indemnity Benefit, U-IMC-132-A AR (05/11) (Form)

Comment: Please note that, although rehab facilities are licensed as hospitals in Arkansas, they are included in the definition of "convalescent nursing homes" according to RR 18 Sec. 5C. Many insureds believe they will be covered by an in-hospital benefit if they are confined in a rehab facility, especially when the rehab is located within a hospital. Since policyholders do not know about the classification of rehab facilities, we request you add to exclusion #1 that rehabilitation facilities are excluded from coverage. We believe this will make the terms of the rider clear to our insureds.

If rehab facilities will be covered by this benefit, please add that to the hospital definition.

Objection 4

SERFF Tracking Number: ZURC-127626045 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 49957
Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

- Travel Assistance Coverage, U-IMC-137-A CW (05/11) (Form)

Comment: 1. Please explain how this rider would work in an emergency situation. If a physician determines that an insured must be immediately evacuated to another medical facility due to a life-threatening emergency, for example, would the insured be covered if there was not sufficient time to pre-authorize the transport? Could the insured be evacuated and then have the evacuation approved retroactively if the company found it to be satisfactory and would have given pre-authorization if time had permitted?

2. Our Department will not approve exclusions for terrorism or other similar language in life or accident and health contracts. Please remove this exclusion.

Objection 5

- [Out of Country] Accident Medical Expense Benefit, U-IMC-138-A AR (05/11) (Form)

Comment: Please refer to the objection to the In-Hospital rider regarding rehabilitation facilities .

Objection 6

- Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage, U-IMC-146-A CW (05/11) (Form)

Comment: Will these benefits be paid in addition to the benefits under the policy if the policy also covers dismemberment?

Objection 7

- Critical Illness Coverage, U-IMC-140-A AR (05/11) (Form)

Comment: This benefits of this rider cannot be excluded from the terms of Section VIII, How to File a Claim, of the policy. Please remove: If [You die] [the Covered Person dies] before We receive notice of a claim under the Policy, no Critical Illness Coverage is payable.

Objection 8

- Waiver of Premium Due to Loss of Employment Benefit, U-IMC-144-A CW (05/11) (Form)

Comment: 1. Is it true that as little as one month's permium can be waived by this rider? What happens to the rider after the waiver period ends?

2. Does the insured have the option to terminate this rider at any time? I am wondering about an insured retiring and having to pay for coverage he cannot use. What if an insured decides to permanently leave the workforce?

3. What is the charge for this rider?

Objection 9

- [Out of Country] Accident Excess Integrated Medical Expense Benefit, U-IMC-121-A AR (05/11) (Form)

- [Out of Country] Accident Excess Corridor Medical Expense Benefit, U-IMC-122-A AR (05/11) (Form)

SERFF Tracking Number: ZURC-127626045 State: Arkansas
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Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Comment: 1. Please provide an example showing how these riders work. Also, I understand that benefits under these riders will begin in the event of the exhaustion of the limit of insurance of the In Force Policy, but please explain "reduction" of the limit of insurance of the In Force Policy.

2. How do these riders compare?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 11/17/2011
 Submitted Date 11/17/2011

Dear Donna Lambert,

Comments:

Ms. Lambert, Thank you for your recent correspondence date October 17th. We will respond to the Department's concerns in the same order as your letter.

Response 1

Comments: If an applicant chose the Catastrophe Cash Benefit Rider, the Coma Benefit rider would not be available to them. Benefits for a Covered Accident resulting in a Coma are paid similarly in both riders. As a result, it would be unreasonable for both riders to be purchased.

Related Objection 1

Applies To:

- Catastrophe Cash Benefit, U-IMC-125-A AR (05/11) (Form)
- Coma Benefit, U-IMC-127-A AR (05/11) (Form)

Comment:

If an insured has the Catastrophe rider and the Coma rider, will benefits from both riders be paid if the insured becomes comatose?

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: 11-17-11 response - redlined forms

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
In-Hospital Indemnity	U-IMC-		Policy/Contract/Fraternal	Initial		47.000	U-IMC-

<i>SERFF Tracking Number:</i>	ZURC-127626045	<i>State:</i>	Arkansas
<i>Filing Company:</i>	Zurich American Insurance Company	<i>State Tracking Number:</i>	49957
<i>Company Tracking Number:</i>	CW AH 33365		
<i>TOI:</i>	H03I Individual Health - Accidental Death & Dismemberment	<i>Sub-TOI:</i>	H03I.000 Health - Accidental Death & Dismemberment
<i>Product Name:</i>	Additional Riders for Accident Insurance Policy		
<i>Project Name/Number:</i>	Additional Riders for Accident Insurance Policy/CW AH 33365		
Benefit	132-A AR (05/11)	Certificate: Amendment, Insert Page, Endorsement or Rider	132-A AR - In- Hospital Indemnity Benefit.CL N.pdf

Previous Version

<i>In-Hospital Indemnity Benefit</i>	<i>U-IMC- 132-A AR (05/11)</i>	<i>Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider</i>	<i>Initial 47.000</i>	<i>U-IMC- 132-A AR - In- Hospital Indemnity Benefit.pdf</i>
<i>[Out of Country] Accident Medical Expense Benefit</i>	<i>U-IMC- 138-A AR (05/11)</i>	<i>Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider</i>	<i>Initial 37.000</i>	<i>U-IMC- 138-A AR - AME Primary.C LN.pdf</i>

Previous Version

<i>[Out of Country] Accident Medical Expense Benefit</i>	<i>U-IMC- 138-A AR (05/11)</i>	<i>Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider</i>	<i>Initial 37.000</i>	<i>U-IMC- 138-A AR - AME Primary.p df</i>
<i>Critical Illness Coverage</i>	<i>U-IMC- 140-A AR (05/11)</i>	<i>Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider</i>	<i>Initial 41.000</i>	<i>U-IMC- 140-A AR - Critical Illness Coverage. CLN.pdf</i>

Previous Version

<i>Critical Illness Coverage</i>	<i>U-IMC- 140-A AR (05/11)</i>	<i>Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider</i>	<i>Initial 41.000</i>	<i>U-IMC- 140-A AR - Critical Illness</i>
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SERFF Tracking Number: ZURC-127626045 State: Arkansas
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Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Coverage.
pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: We respectfully request the Department to reconsider. Our Policy does not exclude for acts of terrorism and the Policy does automatically provide coverage for death or dismemberment that occurs as the result of an act of terrorism. The Terrorism Benefit rider simply provides an additional lump sum benefit if the death or dismemberment was caused directly by an Act of Terrorism.

Related Objection 1

Applies To:

- Terrorism Benefit, U-IMC-136-A CW (05/11) (Form)

Comment:

Our Department will not approve exclusions for terrorism or other similar language in life or accident and health contracts; therefore, acts of terrorism are automatically covered by the policy to which this rider is intended to be attached. Please note that exclusion 10 in the policy does not apply to the release of nuclear energy or radiation if it occurs as an act of terrorism.

Please remove this rider.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: In consideration of the Department's comments, we amended our definition of hospital to exclude a rehabilitation facility. Please see revised form U-IMC-132-A AR.

Related Objection 1

Applies To:

- In-Hospital Indemnity Benefit, U-IMC-132-A AR (05/11) (Form)

SERFF Tracking Number: ZURC-127626045 State: Arkansas
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 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Comment:

Please note that, although rehab facilities are licensed as hospitals in Arkansas, they are included in the definition of "convalescent nursing homes" according to RR 18 Sec. 5C. Many insureds believe they will be covered by an in-hospital benefit if they are confined in a rehab facility, especially when the rehab is located within a hospital. Since policyholders do not know about the classification of rehab facilities, we request you add to exclusion #1 that rehabilitation facilities are excluded from coverage. We believe this will make the terms of the rider clear to our insureds.

If rehab facilities will be covered by this benefit, please add that to the hospital definition.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
In-Hospital Indemnity Benefit	U-IMC-132-A AR (05/11)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		47.000	U-IMC-132-A AR - In-Hospital Indemnity Benefit.CL N.pdf

Previous Version

In-Hospital Indemnity Benefit	U-IMC-132-A AR (05/11)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		47.000	U-IMC-132-A AR - In-Hospital Indemnity Benefit.pdf
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No Rate/Rule Schedule items changed.

SERFF Tracking Number: ZURC-127626045 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 49957
Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Response 4

Comments: While it may initially seem unreasonable to require prior notification, we feel that circumstances involving travel away from the home require timely communication. For example, an Insured that contacts the toll free number is more likely to safely arrange and coordinate medical care in a country where medical services may be difficult to obtain. No papers need to be completed at the time of the call. All that is required for prior approval is pertinent information regarding the medical or travel issue involved. We understand the Department's concerns and would certainly waive the requirement if circumstances made it unreasonable to contact us prior to services or transport.

Again, we respectfully, request the Department to reconsider. When we explain that we will suspend, curtail or limit coverage in the event of instances including terrorism, it is a service we refer to and not coverage. Additionally, it seems unreasonable that we would be required to provide a service when circumstances beyond our control would dictate otherwise.

Related Objection 1

Applies To:

- Travel Assistance Coverage, U-IMC-137-A CW (05/11) (Form)

Comment:

1. Please explain how this rider would work in an emergency situation. If a physician determines that an insured must be immediately evacuated to another medical facility due to a life-threatening emergency, for example, would the insured be covered if there was not sufficient time to pre-authorize the transport? Could the insured be evacuated and then have the evacuation approved retroactively if the company found it to be satisfactory and would have given pre-authorization if time had permitted?
2. Our Department will not approve exclusions for terrorism or other similar language in life or accident and health contracts. Please remove this exclusion.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

SERFF Tracking Number: ZURC-127626045 State: Arkansas
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 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Comments: In consideration of the Department's comments, we amended our definition of hospital to exclude a rehabilitation facility. Please see revised form U-IMC-138-A AR.

Related Objection 1

Applies To:

- [Out of Country] Accident Medical Expense Benefit, U-IMC-138-A AR (05/11) (Form)

Comment:

Please refer to the objection to the In-Hospital rider regarding rehabilitation facilities .

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
[Out of Country] Accident Medical Expense Benefit	U-IMC-138-A AR (05/11)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		37.000	U-IMC-138-A AR - AME Primary.C LN.pdf

Previous Version

[Out of Country] Accident Medical Expense Benefit	U-IMC-138-A AR (05/11)		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		37.000	U-IMC-138-A AR - AME Primary.p df
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No Rate/Rule Schedule items changed.

Response 6

Comments: With the Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage rider, there is an additional benefit offered if the dismembered body part is surgically attached. The rider also provides options to receive benefits for the covered loss of use and paralysis of limbs that the base policy does not provide. However, the rider is not paid in addition to the Accidental Dismemberment Coverage provided under the Policy. Instead, the Policyholder

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Product Name: Additional Riders for Accident Insurance Policy
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will be able to purchase what is in the Policy or this rider, but not both.

Related Objection 1

Applies To:

- Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage, U-IMC-146-A CW (05/11) (Form)

Comment:

Will these benefits be paid in addition to the benefits under the policy if the policy also covers dismemberment?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments: In Consideration of the Department's comments, we removed "If [You die][the Covered Person dies] before We receive notice of a claim under the Policy, no Critical Illness Coverage is payable." Please see revised from U-IMC-140-A AR.

Related Objection 1

Applies To:

- Critical Illness Coverage, U-IMC-140-A AR (05/11) (Form)

Comment:

This benefits of this rider cannot be excluded from the terms of Section VIII, How to File a Claim, of the policy. Please remove: If [You die] [the Covered Person dies] before We receive notice of a claim under the Policy, no Critical Illness Coverage is payable.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability Attach
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SERFF Tracking Number: ZURC-127626045 State: Arkansas
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 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

	Number	Date	Specific Data	Score	Document
Critical Illness Coverage	U-IMC-140-A AR (05/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	41.000	U-IMC-140-A AR - Critical Illness Coverage. CLN.pdf

Previous Version

Critical Illness Coverage	U-IMC-140-A AR (05/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	41.000	U-IMC-140-A AR - Critical Illness Coverage. pdf
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No Rate/Rule Schedule items changed.

Response 8

- Comments: 1. Premium may be waived for as little as 30 days. After the waiver period ends, the rider may still be utilized if the Insured becomes unemployed but the Policy must remain in force.
 2. If the Insured retires while his or Policy is still in force, they may request to cancel this Rider at that (or any) time. An Insured would not be eligible for the benefits of this rider unless they were involuntarily unemployed.
 3. The cost of this rider is reflected on Exhibit 1 located on page 7 of the rate schedule. The factors listed are multiplied by the base policy and whatever riders chosen by the Insured to obtain the cost of the Waiver of Premium rider.

Related Objection 1

Applies To:

- Waiver of Premium Due to Loss of Employment Benefit, U-IMC-144-A CW (05/11) (Form)

Comment:

1. Is it true that as little as one month's permium can be waived by this rider? What happens to the rider after the waiver period ends?
2. Does the insured have the option to terminate this rider at any time? I am wondering about an insured retiring and having to pay for coverage he cannot use. What if an insured decides to permanently leave the workforce?
3. What is the charge for this rider?

SERFF Tracking Number: ZURC-127626045 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 49957
Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 9

Comments: As noted, benefits under these riders begin after the reduction or exhaustion of the limits of another In Force Policy. The "reduction" of the limit of insurance of the In Force Policy refers to the fact that the deductible and benefit payments must be made on another In Force Policy so that the excess benefits of these riders can be calculated and paid.

The difference between these riders is that with the "Corridor" rider, form U-IMC-122-A AR, prior to paying benefits, we will also require the satisfaction of a deductible for this rider. Although, there is a potential for payment of two deductibles, they serve a purpose to offset the costs of two separate policies. You'll note that with our Integrated Rider (form U-IMC-121-A AR), we permit the satisfaction (or reduction) of this rider's deductible, if another insurance plan's deductible was satisfied or reduced.

As an example of how these riders work, let's take two people; both experience an accident and are eligible to receive medical expenses. Both have another In Force Policy that covers medical expenses. These policies have a maximum benefit amount of \$10,000. These In Force policies cover 80% and have a deductible of \$200.

If the benefit amount is exhausted, both riders will pay benefits beyond the maximum of the In Force policy up to the maximum stated in the Rider. If however, say only 70% was paid, the riders will pay benefits beyond 70% up to the maximum stated in the rider.

Further, in the above example, if \$100 of the \$200 deductible was paid on the other In Force Policy, then the "Integrated" rider will correspondingly reduce the amount of the deductible required for this rider to \$100. If the entire amount of \$200 was satisfied for the other In Force policy, then the deductible required for the "Integrated" rider will be satisfied.

Related Objection 1

Applies To:

- [Out of Country] Accident Excess Integrated Medical Expense Benefit, U-IMC-121-A AR (05/11) (Form)

SERFF Tracking Number: ZURC-127626045 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 49957
Company Tracking Number: CW AH 33365
TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Additional Riders for Accident Insurance Policy
Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

- [Out of Country] Accident Excess Corridor Medical Expense Benefit, U-IMC-122-A AR (05/11) (Form)

Comment:

1. Please provide an example showing how these riders work. Also, I understand that benefits under these riders will begin in the event of the exhaustion of the limit of insurance of the In Force Policy, but please explain "reduction" of the limit of insurance of the In Force Policy.

2. How do these riders compare?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Karen Falbo

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
 Company Tracking Number: CW AH 33365
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Form Schedule

Lead Form Number: U-IMC-100

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/22/2011	U-IMC-101-B AR (05/11)	Application/ Enrollment Form	Application Accident Insurance	Revised	Replaced Form #: U-IMC-101-A AR (08/09) Previous Filing #: 44259	49.000	U-IMC-101-B AR - Application.pdf
Approved 11/22/2011	U-IMC-117-A AR (05/11)	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accident [Weekly] Indemnity Benefit	Initial		36.000	U-IMC-117-A AR - Accident [Weekly] Indemnity Benefit.pdf
Approved 11/22/2011	U-IMC-119-A CW (05/11)	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children	Initial		59.000	U-IMC-119-A CW - Ax Dsmbr Loss of Use Coverage for Dependent Children.pdf
Approved 11/22/2011	U-IMC-121-A AR (05/11)	Policy/Cont ract/Fraternal Certificate: Amendment, Insert Page,	[Out of Country] Accident Excess Integrated Medical Expense Benefit	Initial		38.000	U-IMC-121-A AR - AME XS Integrated.pdf

<i>SERFF Tracking Number:</i>	ZURC-127626045	<i>State:</i>	Arkansas	
<i>Filing Company:</i>	Zurich American Insurance Company	<i>State Tracking Number:</i>	49957	
<i>Company Tracking Number:</i>	CW AH 33365			
<i>TOI:</i>	H03I Individual Health - Accidental Death & Dismemberment	<i>Sub-TOI:</i>	H03I.000 Health - Accidental Death & Dismemberment	
<i>Product Name:</i>	Additional Riders for Accident Insurance Policy			
<i>Project Name/Number:</i>	Additional Riders for Accident Insurance Policy/CW AH 33365			
	Endorsement or Rider			
Approved 11/22/2011	U-IMC-122-A AR (05/11)	Policy/Cont [Out of Country] ract/Fraternal Corridor Medical Certificate: Expense Benefit Amendment, Insert Page, Endorsement or Rider	Initial 38.000	U-IMC-122-A AR - AME XS Corridor.pdf
Approved 11/22/2011	U-IMC-125-A AR (05/11)	Policy/Cont Catastrophe Cash ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial 46.000	U-IMC-125-A AR - Catastrophe Cash Benefit.pdf
Approved 11/22/2011	U-IMC-127-A AR (05/11)	Policy/Cont Coma Benefit ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial 54.000	U-IMC-127-A AR - Coma Benefit.pdf
Approved 11/22/2011	U-IMC-129-A CW (05/11)	Policy/Cont Emergency Treatment Benefit ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial 44.000	U-IMC-129-A CW - Emergency Treatment Benefit.pdf

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
 Company Tracking Number: CW AH 33365
 TOI: H031 Individual Health - Accidental Death & Sub-TOI: H031.000 Health - Accidental Death & Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Approval Date	Policy/Cont	Benefit Description	Initial	Amount	Benefit File Name
11/22/2011	U-IMC-130-	Policy/Cont Funeral Expense ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	54.000	U-IMC-130-A CW - Funeral Expense Benefit.pdf
11/22/2011	U-IMC-132-	Policy/Cont In-Hospital Indemnity ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	47.000	U-IMC-132-A AR - In- Hospital Indemnity Benefit.CLN.p df
11/22/2011	U-IMC-134-	Policy/Cont Personal Property ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	34.000	U-IMC-134-A CW - Personal Property Benefit.pdf
11/22/2011	U-IMC-136-	Policy/Cont Terrorism Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	47.000	U-IMC-136-A CW - Terrorism Benefit.pdf

SERFF Tracking Number:	ZURC-127626045	State:	Arkansas	
Filing Company:	Zurich American Insurance Company	State Tracking Number:	49957	
Company Tracking Number:	CW AH 33365			
TOI:	H03I Individual Health - Accidental Death & Dismemberment	Sub-TOI:	H03I.000 Health - Accidental Death & Dismemberment	
Product Name:	Additional Riders for Accident Insurance Policy			
Project Name/Number:	Additional Riders for Accident Insurance Policy/CW AH 33365			
Approved	U-IMC-137-Policy/Cont Travel Assistance	Initial	44.000	U-IMC-137-A
11/22/2011	A CW ract/Fratern Coverage			CW - Travel
(05/11)	al			Assistance
	Certificate:			Coverage.pdf
	Amendmen			
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved	U-IMC-138-Policy/Cont [Out of Country]	Initial	37.000	U-IMC-138-A
11/22/2011	A AR ract/Fratern Accident Medical			AR - AME
(05/11)	al Expense Benefit			Primary.CLN.
	Certificate:			pdf
	Amendmen			
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved	U-IMC-140-Policy/Cont Critical Illness	Initial	41.000	U-IMC-140-A
11/22/2011	A AR ract/Fratern Coverage			AR - Critical
(05/11)	al			Illness
	Certificate:			Coverage.CL
	Amendmen			N.pdf
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved	U-IMC-143-Policy/Cont Wellness Benefit	Initial	42.000	U-IMC-143-A
11/22/2011	A CW ract/Fratern			CW -
(05/11)	al			Wellness
	Certificate:			Benefit.pdf
	Amendmen			
	t, Insert			
	Page,			
	Endorseme			
	nt or Rider			
Approved	U-IMC-144-Policy/Cont Waiver of Premium	Initial	50.000	U-IMC-144-A

<i>SERFF Tracking Number:</i>	ZURC-127626045	<i>State:</i>	Arkansas
<i>Filing Company:</i>	Zurich American Insurance Company	<i>State Tracking Number:</i>	49957
<i>Company Tracking Number:</i>	CW AH 33365		
<i>TOI:</i>	H03I Individual Health - Accidental Death & Dismemberment	<i>Sub-TOI:</i>	H03I.000 Health - Accidental Death & Dismemberment
<i>Product Name:</i>	Additional Riders for Accident Insurance Policy		
<i>Project Name/Number:</i>	Additional Riders for Accident Insurance Policy/CW AH 33365		
11/22/2011 A CW (05/11)	ract/Fraternal Due to Loss of Employment Benefit Certificate: Amendment, Insert Page, Endorsement or Rider		CW - Waiver of Premium for Loss of Employment.pdf
Approved 11/22/2011 A CW (05/11)	U-IMC-145-Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	No Claim Discount Initial 63.000	U-IMC-145-A CW - No Claim Discount.pdf
Approved 11/22/2011 A CW (05/11)	U-IMC-146-Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage Initial 58.000	U-IMC-146-A CW - Ax Dsmbr Loss of Use Coverage.pdf

Application

Accident Insurance



Zurich American Insurance Company
 1400 American Lane
 Schaumburg, Illinois 60196

APPLICANT INFORMATION			
Full Legal Name (First, Middle Initial and Last):		[Last 4 Digits of SSN: XXX-XX-]	
Address:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone: - -	

[SPOUSE [or DOMESTIC PARTNER] INFORMATION (if Applicant is applying for Dependent coverage)	
Full Legal Name (First, Middle Initial and Last):	Date of Birth (MM/DD/YYYY):]

[DEPENDENT CHILD(REN) INFORMATION (if Applicant is applying for Dependent coverage) [If you wish to add more Dependent Child(ren), please attach a separate sheet of paper and include all the information requested.]	
Full Legal Name (First, Middle Initial and Last):	Date of Birth (MM/DD/YYYY):
Full Legal Name (First, Middle Initial and Last):	Date of Birth (MM/DD/YYYY):
[Full Legal Name (First, Middle Initial and Last):	Date of Birth (MM/DD/YYYY):]
[Full Legal Name (First, Middle Initial and Last):	Date of Birth (MM/DD/YYYY):]]

INSURANCE REQUESTED	
Plan Selected (please check each box that applies):	Principal Sum (coverage amount)
<input type="checkbox"/> Applicant	\$
<input type="checkbox"/> plus Spouse [or Domestic Partner] Only	[as per the Policy Schedule]
<input type="checkbox"/> plus Dependent Child(ren) Only	[as per the Policy Schedule]
<input type="checkbox"/> plus Spouse [or Domestic Partner] and Dependent Child(ren)	[as per the Policy Schedule]
[The Principal Sum for Covered Dependents will be a percentage of the Applicant's Principal Sum .]	
[Coverage(s) Included:	Coverage Amount
[Accidental Death Coverage]	[as per the Policy Schedule]
[Dismemberment Coverage]	[as per the Policy Schedule]
[Exposure and Disappearance Coverage]	[as per the Policy Schedule]
[Critical Illness Coverage [for:] [Cancer/Cancerous] [Heart Attack (Myocardial Infarction)] [Kidney Failure] [Loss of Limb(s)] [Major Organ Transplant] [Paralysis]	[as per the Policy Schedule]

[Stroke (Cerebrovascular Accident)]	
[]	[as per the Policy Schedule]
[Benefit(s) Included:	Benefit Amount
[[Higher] Education Benefit]	[as per the Policy Schedule]
[Common Carrier Benefit]	[as per the Policy Schedule]
[Common Disaster Benefit]	[as per the Policy Schedule]
[Carjacking Benefit]	[as per the Policy Schedule]
[Felonious Assault Benefit]	[as per the Policy Schedule]
[Identity Theft Resolution Services]	[as per the Policy Schedule]
[Rehabilitation Benefit]	[as per the Policy Schedule]
[Seat Belt/[Air Bag] Benefit]	[as per the Policy Schedule]
[Accident [Weekly] Indemnity Benefit]	[as per the Policy Schedule]
[Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children]	[as per the Policy Schedule]
[[Out of County] Accident Excess Integrated Medical Expense Benefit [with a Coinsurance Percentage of %]]	[as per the Rider]
[[Out of Country] Accident Excess Corridor Medical Expense Benefit [with a Coinsurance Percentage of %]]	[as per the Rider]
[Catastrophe Cash Benefit]	[as per the Policy Schedule]
[Coma Benefit]	[as per the Policy Schedule]
[Emergency Treatment Benefit]	[as per the Policy Schedule]
[Funeral Expense Benefit]	[as per the Policy Schedule]
[In-Hospital Indemnity Benefit]	[as per the Policy Schedule]
[Personal Property Benefit]	[as per the Policy Schedule]
[Terrorism Benefit]	[as per the Policy Schedule]
[Travel Assistance Coverage]	[as per the Policy Schedule]
[[Out of County] Accident Medical Expense Benefit [with a Coinsurance Percentage of %]]	[as per the Rider]
[Wellness Benefit]	[as per the Policy Schedule]
[Waiver of Premium Due to Loss of Employment Benefit]	[as per the Policy Schedule]
[No Claim Discount]	[as per the Rider]
[Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage]	[as per the Policy Schedule]
[]	[as per the Policy Schedule]

[CRITICAL ILLNESS COVERAGE QUESTIONNAIRE	
1. Has the Applicant [, Spouse [or Domestic Partner]] [, or Dependent Child(ren)] ever been diagnosed with or treated for any of the following (<i>Oregon residents only</i> : 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. stroke, transient ischemic attack (TIA), intermittent or persistent paralysis or other brain or neurological disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. emphysema, chronic bronchitis, asthma, respiratory system conditions or any lung disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. liver disease, hepatitis, cirrhosis, kidney failure, polycystic disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. [cancer, leukemia, Hodgkin's disease, melanoma, malignant tumor, growth, lesion or mass of any type?	<input type="checkbox"/> YES <input type="checkbox"/> NO

2. Has the Applicant [, 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)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has the Applicant [, 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO

BENEFICIARY DESIGNATION		
It is important that your beneficiary designation be clear so that there will be no question as to your intent. If you wish to name more than 1 primary or 1 contingent beneficiary, please attach a separate sheet of paper and include all the information requested. NOTE: If designating more than 1 primary or 1 contingent beneficiary, the total % of share should not exceed 100% for each.		
Primary Beneficiary (this beneficiary is the first in line to receive benefit(s)):		
Name (If an Individual, include First, Middle Initial and Last):	Date of Birth/Trust (MM/DD/YYYY):	% Share:
Relationship: [] [<input type="checkbox"/> Spouse <input type="checkbox"/> Non-Spouse Individual <input type="checkbox"/> Trust <input type="checkbox"/> Estate <input type="checkbox"/> Charity or Other Entity]		[SSN/Tax ID:]
Contingent Beneficiary (this beneficiary will only receive benefit(s) if the primary beneficiary has died):		
Name (If an Individual, include First, Middle Initial and Last):	Date of Birth/Trust (MM/DD/YYYY):	% Share:
Relationship: [] [<input type="checkbox"/> Spouse <input type="checkbox"/> Non-Spouse Individual <input type="checkbox"/> Trust <input type="checkbox"/> Estate <input type="checkbox"/> Charity or Other Entity]		[SSN/Tax ID:]
If more than one primary and/or contingent beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the Insured's estate, unless otherwise provided in the Accident Policy.		

[PREMIUM INFORMATION:	
Applicant:	[\$0.000] [per \$[1,000] of Principal Sum] [per month]
[plus Spouse [or Domestic Partner] Only:	plus [\$0.000] [per \$[1,000] of Principal Sum] [per month]]
[plus Dependent Child(ren) Only:	plus [\$0.000] [per \$[1,000] of Principal Sum] [per month]]
[plus Spouse [or Domestic Partner] and Dependent Child(ren) :	plus [\$0.000] [per \$[1,000] of Principal Sum] [per month]]
[Annual Premium Option:	[\$40.00]]
Frequency of Payment: [<input type="checkbox"/> Annually] [<input type="checkbox"/> Semi-Annually] [<input type="checkbox"/> Quarterly] [<input type="checkbox"/> Monthly]	
Method of Payment: [<input type="checkbox"/> Credit Card] [<input type="checkbox"/> Bank Draft] [<input type="checkbox"/> Direct Bill] [The Applicant must complete a separate authorization form for a Credit Card or Bank Draft payment.]	

INSURANCE FRAUD WARNING

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

The Applicant hereby applies for Accident Insurance and declares that:

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

It is hereby understood and agreed that:

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

[[If selecting additional insurance coverage,] I authorize my premium to be billed monthly and electronically remitted to the Program Administrator from my [ABC Bank] [checking] account. This authority is to remain in effect until I cancel it by written notification to the Program Administrator [at least 30 days] in advance of the intended termination date of my coverage. Coverage begins on the Effective Date stated on the Policy Schedule provided the first premium payment is paid. [Note: Coverage amounts begin to decrease at age [70].] [If I sign and return this form without selecting a coverage [amount] [type], I understand that I will automatically be enrolled for [the lowest level of] [\$xx,xxx of] [Single] Coverage available.]]

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

Applicant's Signature (may be electronic): _____

Date: _____

[FOR COMPANY USE ONLY

[SPONSORING ORGANIZATION INFORMATION

Legal Name:

ID Number:]

[PRODUCER INFORMATION

Writing Agent or Broker Name:

Producer Number:]]



ZURICH[®]

Accident [Weekly] Indemnity Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury**, which renders [You] [the **Covered Person**] **Totally Disabled**, **We** will pay an Accident [Weekly] Indemnity Benefit provided:

1. the **Total Disability** occurs within [thirty (30)] days of the date of the **Covered Injury**; and
2. [You are] [the **Covered Person** is] being attended to by a duly licensed **Physician**.

Payments will begin on the first day of **Total Disability** and will continue for as long as [You are] [the **Covered Person** is] **Totally Disabled**. The amount of the payments will be equal to the amount shown on the Schedule [reduced by [(1) Workers' Compensation Disability Benefit]; [(2) Social Security Disability Benefits excluding any amounts for which **Your Dependents** may qualify because of **Your** disability]; [(3) Social Security Retirement Benefits]; [(4) Group Disability Benefits]; [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance]].

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

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

Total Disability (Totally Disabled) means disability that: (1) prevents [You] [a **Covered Person**] from performing the material and substantial duties of [Your] [the **Covered Person's**] occupation [or if for [You] [a **Covered Person**] who is not employed means that [You are] [the **Covered Person** is] unable to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of [Your's] [the **Covered Person's**] immediately prior to the **Accident** and (2) requires the **Continuous Care** and treatment of a **Physician**. If [You do] [the **Covered Person** does] not adhere to the treatment plan the **Physician** prescribes relating to [Your] [the **Covered Person's**] disabling condition, [You] [the **Covered Person**] shall not qualify for the **Total Disability Benefit**. [You] [The **Covered Person**] shall not qualify for **Total Disability** if [You engage] [the **Covered Person** engages] in any activity that results in earned income.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If a **Covered Injury** to [a] **Dependent Child(ren)** results in any of the following **Covered Losses**, **We** will pay the percentage of **Principal Sum** applicable to that **Covered Person** as shown on the Schedule. The **Covered Loss** must occur within [365] days of the **Covered Accident**.

The benefit amounts are based on the percentage of the **Principal Sum** shown in the Schedule for the person suffering the **Covered Loss**.

Covered Loss of	Percentage of the Insured's Principal Sum
1. Both Hands or Both Feet	[50%] to a maximum of \$[100,000]
2. One Hand and One Foot	[50%] to a maximum of \$[100,000]
3. One Hand or One Foot plus the loss of Sight of One Eye	[50%] to a maximum of \$[100,000]
4. Sight of Both Eyes	[50%] to a maximum of \$[100,000]
5. Speech and Hearing	[50%] to a maximum of \$[100,000]
6. Speech or Hearing	[25%] to a maximum of \$[50,000]
7. One Hand; One Foot; or Sight of One Eye	[25%] to a maximum of \$[50,000]
8. Thumb and Index Finger on the same Hand	[12.5%] to a maximum of \$[25,000]
9. [Hearing in One Ear	[12.5%] to a maximum of \$[25,000]]

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

[Covered Loss of Use of	Percentage of the Insured's Principal Sum
1. Four Limbs	[50%] to a maximum of \$[100,000]
2. Three Limbs	[37.5%] to a maximum of \$[75,000]
3. Two Limbs	[33%] to a maximum of \$[66,000]
4. One Limb	[25%] to a maximum of \$[50,000]]

[Plegia	Percentage of the Insured's Principal Sum
1. Quadriplegia (total paralysis of all four Limbs)	[50%] to a maximum of \$[100,000]
2. [Triplegia (total paralysis of three Limbs)	[37.5%] to a maximum of \$[75,000]]
3. [Paraplegia (total paralysis of both lower Limbs)	[33%] to a maximum of \$[66,000]]
4. [Hemiplegia (total paralysis of upper and lower Limbs	

on one side of the body) [25%] to a maximum of \$[50,000]]

5. [Uniplegia (total paralysis of one **Limb**) [12.5%] to a maximum of \$25,000]]

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

Covered Loss means:

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

[**Covered Loss** includes [**Covered Loss of Use**] [and] [**Plegia**].]

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

[**Limb** means an entire arm or a leg.]

[**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be total, permanent, complete and irreversible paralysis of [one (1)] or more **Limb(s)**. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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



ZURICH®

[Out of Country] Accident Excess Integrated Medical Expense Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

Accident Medical Expense Schedule			
Benefit	Maximum Benefit [per Covered Person] per Covered Accident	Deductible [per Covered Person] per Covered Accident	Coinsurance Percentage [per Covered Person] per Covered Accident w/no In Force Policy
Accident Medical	[\$10,000]	[\$100]	[50]%
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[50]%
[Pregnancy]	[\$1,000]	[\$100]	[50]%
[Custodial Services]	[\$1,000]	[\$100]	[50]%

We will pay the [Usual and Customary] expenses for **Medically Necessary Covered Medical Service(s)** [and **Custodial Services**] incurred by [You] [the **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 additional definitions apply:

Coinsurance Percentage means the percentage of the **Usual and Customary** expenses for **Medically Necessary Covered Medical Services** [and **Custodial Services**] to be paid by the **Covered Person** after satisfaction of the deductible.

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

1. **Hospital** room and board expenses: the daily room rate when [You are] [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.
9. The services of a registered nurse not **Related** to **[You]** [the **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, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless 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 **[You]** [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 **[You]** [the **Covered Person**];
2. related to performing, or assisting **[You]** [the **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 **[You]** [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 [You] [the **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 health care policy covering [You] [the **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 [You] [a **Covered Person**] back to [Your] [the **Covered Person's**] principal residence or to the country where [You were] [the **Covered Person** was] assigned due to [You] [the **Covered Person**] being injured.]

Pre-existing Condition means a condition for which [You] [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**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary 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 Section IV of 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** until 12 months after the effective date of this Rider.
4. **Covered Injury** for which [You are] [the **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 [You] [the **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 [**You are**] [the **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. [**You**] [A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in [**Your**] [the **Covered Person's**] 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 [**Your**] [the **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, [**You**][the **Covered Person**] will be required to contribute a **Coinsurance Percentage** of [50%], and the **Policy** will pay benefits after applying both the deductible and the **Coinsurance Percentage**.

[SUBROGATION

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

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

[Out of Country] Accident Excess Corridor Medical Expense Benefit



Zurich American Insurance Company
 1400 American Lane
 Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

Accident Medical Expense Schedule			
Benefit	Maximum Benefit [per Covered Person] per Covered Accident	Deductible [per Covered Person] per Covered Accident	Coinsurance Percentage [per Covered Person] per Covered Accident w/no In Force Policy
Accident Medical	[\$10,000]	[\$100]	[50]%
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[50]%
[Pregnancy]	[\$1,000]	[\$100]	[50]%
[Custodial Services]	[\$1,000]	[\$100]	[50]%

We will pay the [Usual and Customary] Expenses for **Medically Necessary Covered Medical Service(s)** [and **Custodial Services**] incurred by [You] [the **Covered Person**] resulting from a **Covered Accident**, up to the Maximum Benefit shown on the Accident Medical Expense 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 additional definitions apply:

Coinsurance Percentage means the percentage of the **Usual and Customary** expenses for **Medically Necessary Covered Medical Services** [and **Custodial Services**] to be paid by the **Covered Person** after satisfaction of the deductible.

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

1. **Hospital** room and board expenses: the daily room rate when [You are] [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.
9. The services of a registered nurse not **Related** to **[You]** [the **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, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless 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 **[You]** [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 **[You]** [the **Covered Person**];
2. related to performing, or assisting **[You]** [the **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; and
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 **[You]** [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 [You] [the **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 health care policy covering [You] [the **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 [You] [a **Covered Person**] back to [Your] [the **Covered Person's**] principal residence or to the country where [You were] [the **Covered Person** was] assigned prior to [You] [the **Covered Person**] being injured.]

Pre-existing Condition means a condition for which [You] [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**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

[Usual and Customary 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 Section IV of 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** until 12 months after the effective date of this Rider.
4. **Covered Injury** for which [You are] [the **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 [You] [the **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 [You are] [the **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. [You] [A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in [Your] [the **Covered Person's**] 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 [Your] [the **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 CORRIDOR

The benefit amount for this benefit is payable in excess of any **In Force Policy** and its applicable deductible.

In the event and only in the event of the reduction or exhaustion of the limit of insurance of the **In Force Policy** solely as the result of actual payment of benefits covered there under, 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 and the deductible amount, up to the maximum specified on the this rider. In no event will **We** pay more than the maximum amount stated in this rider.

If no **In Force Policy** exists, [You][the **Covered Person**] will be required to contribute a **Coinsurance Percentage** of [50%], and the **Policy** will pay benefits after applying both the deductible and the **Coinsurance Percentage**.

[SUBROGATION]

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

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Catastrophe Cash Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

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

1. is determined by a **Physician** to be permanent and irreversible; and
2. results in **Disability**.

The benefit is payable based on the following table:

Cause of Disability	Percentage of [Principal Sum] [Maximum Amount]
Coma	[100%]
Paralysis of Two or More Limbs (Upper and/or Lower)	[100%]
Brain Death	[100%]
Paralysis of One Limb	[50%]
Paralysis of One or More Other Parts of the Body	See NOTE below

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

If [You suffer] [the **Covered Person** suffers] more than one cause of **Disability** as a result of the same **Covered Accident**, only one percentage of the [**Principal Sum**] [Maximum Amount], the largest for any one Cause of **Disability** suffered by [You] [the **Covered Person**], will be used to determine the benefit payable.

The benefit payable is:

[LUMP SUM: The amount shown on the Schedule.]

[MONTHLY: The benefit is payable monthly as long as [You remain] [the **Covered Person** remains] continuously **Disabled** due to the **Paralysis, Coma, or Brain Death** but ceases on the earliest of:

1. the date [You die] [the **Covered Person** dies]; [or]
2. the date [You are] [the **Covered Person** is] no longer **Disabled** due to the **Paralysis, Coma, or Brain Death**; or
3. the date monthly Catastrophe Cash benefits have been paid for the Maximum Number of Months shown in the Schedule for all **Disabilities** caused by the same **Accident**.]

[LUMP SUM THEN MONTHLY: The Initial Lump Sum amount payable followed by a monthly Catastrophe Cash benefit equal to [the percentage amount for the number of months] [pro-rated by the number of months] [amounts] stated in the Schedule. The monthly Catastrophe Cash benefit is payable monthly as long as [You remain] [the **Covered Person** remains] continuously **Disabled** due to the **Paralysis, Coma, or Brain Death** but ceases on the earliest of:

1. the date [You die] [the **Covered Person** dies]; [or]
2. the date [You are] [the **Covered Person** is] no longer **Disabled** due to the **Paralysis, Coma or Brain Death**;

3. the date monthly Catastrophe Cash benefits have been paid for the Maximum Number of Months shown in the Schedule for all **Disabilities** caused by the same **Accident**.]

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

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

We reserve the right as often as it may reasonably require to determine, on the basis of all the facts and circumstances, that [You are] [the **Covered Person** is] **Disabled** due to the **Paralysis, Coma, or Brain Death** including, but not limited to, requiring an independent medical examination at **Our** expense.

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

Brain Death means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain for [six (6)] consecutive months, even though the heart is still beating.

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

Disabled/Disability(ies) means that due to a **Covered Injury**, [You are] [the **Covered Person** is] unable while under the regular care of a **Physician** to perform the material and substantial duties of the occupation for which [You are] [the **Covered Person** is] qualified by reason of education, experience or training. [However, with respect to [You] [the **Covered Person**] for whom an occupational definition of **Disabled/Disability** is not appropriate, **Disabled/Disability** means that [You are] [the **Covered Person** is] unable, while under the regular care of a **Physician**, to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of [You] [the **Covered Person**] immediately prior to the **Accident**.]

Periods of **Disability** separated by less than thirty (30) consecutive days will be considered one period of **Disability** resulting from the same **Covered Injury**, unless due to separate and unrelated causes.

Limb means an entire arm or entire leg.

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

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Coma Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss** within [365] days of a **Covered Accident**, and such **Covered Injury** causes [You] [the **Covered Person**] to be in a **Coma**, **We** will pay a Coma Benefit.

The Coma Benefit is equal to the amount shown on the Schedule and will be paid each month [You remain] [the **Covered Person** remains] in a **Coma**. [The Coma Benefit will be payable per the Schedule per month for the first [eleven (11)] months [You remain] [the **Covered Person** remains] in a **Coma**. At the end of the [eleven (11)] months of payment, if [You remain] [the **Covered Person** remains] in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the [eleven (11)] months of benefit already received.]

The Coma Benefit will end on the earliest of the following:

1. the date [You are] [the **Covered Person** is] no longer in a **Coma** that resulted directly from the **Covered Injury**; or
2. [You have] [the **Covered Person** has] received the full Coma Benefit for [100] months.

For the purposes of this rider only, **Coma** means a profound state of unconsciousness from which [You] [the **Covered Person**] cannot be aroused to consciousness, even by powerful stimulation, as determined by a qualified **Physician**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Emergency Treatment Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** that results in a **Covered Loss** and, within [forty-eight (48)] hours of the **Covered Accident**, is required to receive **Medically Necessary Emergency Treatment** [in the emergency room of a **Hospital**], **We** will pay the amount shown on the Schedule. Only one Emergency Treatment Benefit[, the largest,] is payable for any one **Covered Accident** incurred by [You] [each **Covered Person**]. [The maximum number of Emergency Treatment Benefits payable per calendar year to [You] [each **Covered Person**] regardless of the number of **Covered Accidents** incurred, is shown on the Schedule.]

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

Emergency Treatment means treatment for:

1. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the person (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

[Hospital] means an institution which:

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

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

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

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

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

Medically Necessary means an Emergency Treatment that:

1. is essential for the diagnosis, treatment, and care of the **Covered Injury**;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision, or order.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Funeral Expense Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If [You sustain] [a **Covered Person** sustains] a **Covered Injury** that results in a **Covered Loss** payable under the **[Accidental Death]** Coverage, **We** will pay an additional Funeral Expense Benefit amount equal to the Maximum Amount for this Benefit as shown on the Schedule.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

In-Hospital Indemnity Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss** that requires **Hospital Confinement** for more than [seven (7)] consecutive days, **We** will pay the amount shown on the Schedule for a maximum of [twelve (12)] months for any **Covered Injury**. To be eligible for this benefit, the initial **Hospital Confinement** period must begin within [ninety (90)] days of the **Covered Injury**.

Successive periods of **Hospital Confinement** arising out of the same **Covered Injury** will be considered one (1) confinement only if they are separated by a period of less than [three (3)] months.

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

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, skilled nursing facility or rehabilitation 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 Confinement means admission to a **Hospital** as an inpatient [for at least twenty-four (24) consecutive hours] by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to [You] [the **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 rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Personal Property Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** 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** [You sustain] [the **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 [You are] [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 [You] [the **Covered Person**].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Terrorism Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death] Coverage, that was directly caused by an **Act of Terrorism** [within the **United States**] [outside of the **United States**], **We** will pay an additional benefit equal to the amount shown on the Schedule.

For the purposes of this rider only, the following additional definition[s] appl[y][ies]:

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

[**United States** means the United States of America [including] [excluding] its territories, possessions, and protectorates.]

We may cancel this Terrorism Benefit rider by sending **You** at **Your** most recent address in **Our** records, a [ten (10)] day notice of **Our** intent to cancel.

Upon cancellation of this rider, **We** will return any unearned premium that **You** have paid, but this is not a condition of termination. A change in or termination of this rider will not affect a claim that began while this rider was in force. In the event of cancellation of this rider, **You** are responsible for notifying all **Covered Persons**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Travel Assistance Coverage



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

This Travel Assistance Coverage will apply to **You** and **Your Spouse** [/**Domestic Partner**] and/or **Dependent Child(ren)**, if covered under this **Policy**, when traveling [100] mile(s) or more from [Your] [the **Covered Person's**] **Principal Residence**:

The transportation and/or services provided under this Travel Assistance Coverage must be pre-authorized by **Us**.

Under this rider the Travel Assistance Coverage consists of the following:

MEDICAL EVACUATION

If [You are] [a **Covered Person** is] **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care [in accordance with **Western Medical Standards**], **We** will arrange for, and cover the cost for, the transport of [You] [the **Covered Person**] to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for Medical Evacuation is equal to the amount shown on the Schedule.]

MEDICAL REPATRIATION

If [You are] [a **Covered Person** is] **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel on a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to [Your] [the **Covered Person's**] health, **We** will arrange for, and cover the cost for, the transport of [You] [the **Covered Person**] to [Your] [the **Covered Person's**] **Principal Residence**, or to [Your] [the **Covered Person's**] residence in the country where [You are] [the **Covered Person** is] currently assigned (at [Your] [the **Covered Person's**] option), in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered. [The maximum amount **We** will pay for Medical Repatriation is shown on the Schedule].

NON-MEDICAL REPATRIATION

If [You are] [a **Covered Person** is] **Injured** or **Ill** on a **Covered Trip** and [You have] [the **Covered Person** has] sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to [Your] [the **Covered Person's**] health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to [Your] [the **Covered Person's**] **Principal Residence** or to the country where [You are] [the **Covered Person** is] currently assigned (at [Your] [the **Covered Person's**] option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending **Physician**. The upgrade will be subject to **Our** discretion. [The maximum amount **We** will pay for Non-Medical Repatriation is shown on the Schedule].

RETURN OF REMAINS

If [You die] [a **Covered Person** dies] while on a **Covered Trip**, **We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. [The maximum amount **We** will pay for Return of Remains is shown on the Schedule].

VISIT TO HOSPITAL

If [You are] [a **Covered Person** is] scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by [You] [the **Covered Person**] to visit [You] [the **Covered Person**] while [You] [the **Covered Person**] is hospitalized. **We** must pre-authorize the transportation for benefits to be payable. [The maximum amount **We** will pay for Visit to Hospital is shown on the Schedule.].

RETURN OF CHILD

If [You are] [a **Covered Person** is] traveling with [a **Dependent Child(ren)**, who [is] [are] under [nineteen (19)] years of age or [a **Child(ren)** who prior to age [nineteen (19)] became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remain[s] chiefly dependent upon [You] [the **Covered Person**] for support and maintenance, while on a **Covered Trip**, and due to the **Illness** or **Injury** to [You] [the **Covered Person**], such **Dependent Child(ren)** [is] [are] left unattended, **We** will arrange for, and cover the cost of, the transport of the **Dependent Child(ren)** by a regularly scheduled economy class air flight to the location chosen by [You] [the **Covered Person**], and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Dependent Child(ren)** and attendant, if applicable, for benefits to be payable. [The maximum amount **We** will pay for Return of Child is shown on the Schedule.]

RETURN OF COMPANION

If [You are] [a **Covered Person** is] traveling with a companion while on a **Covered Trip**, and due to the **Illness** or **Injury** to [You] [the **Covered Person**] [You] [the **Covered Person**] cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one-way economy class flight. **We** must pre-authorize such costs for benefits to be payable. [The maximum amount **We** will pay for Return of Companion is shown on the Schedule].

TRAVEL ASSISTANCE COVERAGE EXCLUSIONS

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

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment.
2. [the **Illness** requiring medical services resulted from [You] [the **Covered Person**] being under the influence of any controlled substance, unless such controlled substance was prescribed by a **Physician** and was taken in accordance with the prescribed dosage.]
3. [with respect to a medical evacuation, the medical care, which is being provided, is consistent with **Western Medical Standards**. **We** have discretion in making that determination.]
4. with respect to medical evacuation, it is not medically necessary to transport [You] [the **Covered Person**] to another hospital or medical facility. **We** have the sole discretion in making that determination.
5. based upon [Your] [the **Covered Person's**] medical condition of and/or the local conditions and circumstances, **We** determine that medical evacuation or medical repatriation is not appropriate. **We** have discretion in making that determination.
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this Coverage. **We** will be fully and completely excused from performance and discharged from any contractual obligation.
7. **We** did not pre-authorize the transportation and/or services.
8. [the **Illness** resulted in whole or in part from [You] [the **Covered Person**] being intoxicated. [You] [A **Covered Person**] will be conclusively presumed to be intoxicated if on or about the time of the incident which required medical treatment the level of alcohol in his or her blood exceeds the amount at which a person is presumed to be

intoxicated if operating a motor vehicle in that jurisdiction. A report from a law enforcement officer, medical provider or similar report will be considered proof of [Your] [the **Covered Person's**] intoxication.]

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

Covered Trip means when [You are] [a **Covered Person** is] traveling more than [100] miles from [Your] [the **Covered Person's**] **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the Travel Assistance Exclusions set forth above.

Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

Injured, Injury, or Injuries means a bodily injury or injuries and is not limited to accidental bodily injuries.

Principal Residence means [Your] [the **Covered Person's**] legal domicile.

Western Medical Standards means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.]

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

TRAVEL ASSISTANCE COVERAGE – OTHER PROVISIONS

Right of Recovery

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

[Excess Coverage

Our obligation to pay [You] [the **Covered Person**] under this Travel Assistance Coverage will be excess of any other insurance which [You have] [the **Covered Person** has] with respect to the expenses covered under this Travel Assistance Coverage.]

Reservation of Rights

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

[Exempted Countries

This Travel Assistance Coverage is not available in the following countries: [Iran]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to **You**.]

Scope

[Covered transportation expenses will be limited to air and marine conveyance.]

Illness, as covered under this Travel Assistance Coverage, is solely covered under this Travel Assistance Coverage, and in no way supersedes or modifies the other Coverages or Benefits provided under the **Policy**.

[To contact **Us** regarding this Travel Assistance Coverage, [You] [the **Covered Person**] must call [1-800-263-0261] from the U.S. or Canada; and collect from anywhere else in the world at [+1-416-977-0277].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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



ZURICH

[Out of Country] Accident Medical Expense Benefit

Zurich American Insurance Company

1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

Accident Medical Expense Schedule			
Benefit	Maximum Benefit [per Covered Person] per Covered Accident	Deductible [per Covered Person] per Covered Accident	Coinsurance Percentage [per Covered Person] per Covered Accident
Accident Medical	[\$10,000]	[\$100]	[50]%
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[50]%
[Pregnancy]	[\$1,000]	[\$100]	[50]%
[Custodial Services]	[\$1,000]	[\$100]	[50]%

We will pay the [Usual and Customary] expenses for **Medically Necessary Covered Medical Service(s)** [and **Custodial Services**] incurred by [You] [the **Covered Person**] resulting from a **Covered Accident**, up to the Maximum Benefit shown on the Accident Medical Expense 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 additional definitions apply:

Coinsurance Percentage means the percentage of the **Usual and Customary** expenses for **Medically Necessary Covered Medical Services** [and **Custodial Services**] to be paid by the **Covered Person** after satisfaction of the deductible.

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

1. **Hospital** room and board expenses: the daily room rate when [You are] [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.
9. The services of a registered nurse not **Related** to [You] [the **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, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless 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 [You] [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 [You] [the **Covered Person**];
2. related to performing, or assisting [You] [the **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 [You] [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, skilled nursing facility, or rehabilitation 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 [You] [the **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 [You] [a **Covered Person**] back to [Your] [the **Covered Person's**] principal residence or to the country where [You were] [the **Covered Person** was] assigned due to [You] [the **Covered Person**] being injured.]

Pre-existing Condition means a condition for which [You] [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**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

Usual and Customary 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 Section IV of 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** until 12 months after the effective date of this Rider.
4. **Covered Injury** for which [You are] [the **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 [You] [the **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 [**You** are] [the **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. [**You**] [A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in [**Your**] [the **Covered Person's**] 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 [**Your**] [the **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 [**You**] [the **Covered Person**] or on behalf of **Your Spouse or Domestic Partner, Dependent Child(ren)**, heirs, guardians or executors or will be obligated to pay in the future to **You**. If [**You** recover] [the **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 [**You**] [the **Covered Person**]. [**You** agree] [the **Covered Person** agrees] to assist **Us** in preserving **Our** rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Critical Illness Coverage



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

CAUTION: This is a limited policy. Read it carefully with the outline of coverage

This Coverage modifies insurance provided under the Individual Accident Policy.

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

1. Coverage - Under the terms of the Critical Illness Coverage, **We** will pay [**You**] [the **Covered Person**] the **Coverage Amount** as a coverage payment:
 - a. If [**You are**] [the **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**, unless the loss is due to a pre-existing condition for a period greater than 12 months following the effective date of this Rider;
 - 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.
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 [fifty percent (50%)] of the **Coverage Amount** when [**You reach**] [the **Covered Person reaches**] age [sixty-five (65)].
 - b. If the **Policy's Principal Sum** is decreased for any other reason, such that the **Coverage Amount** exceeds [fifty percent (50%)] of the **Principal Sum**, such **Coverage Amount** will be reduced to [fifty percent (50%)] 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 [**You**] [the **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 [\$250,000.00] before any claim is paid. **We** will adjust the premiums for such Coverages and policies and refund to [**You**] 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 [thirty (30)] day **Waiting Period**. Clinical Diagnosis of Cancer shall be accepted as evidence that cancer exists when a pathological diagnosis is medically inappropriate.

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 [thirty (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 [thirty (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 [thirty (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 qualified **Physician** and must first occur after a [thirty (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 [ninety (90)] days. To qualify for the **Coverage Amount**, the **Paralysis** must first occur after a [thirty (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 [thirty (30)] day **Waiting Period**. The **Stroke** must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [thirty (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**. [You] [the **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 [Your] [the **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 **You** 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

[Your] [the **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 (2) years] prior to the later of the Coverage Effective Date or the effective date of any Coverage reinstatement. If [You are] [the **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** for 12 months following the effective date of this Rider.]
 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 [You] [the **Covered Person**] may not exceed [\$250,000.00].
 - b. Only one **Coverage Amount** payment is allowed during [Your] [the **Covered Person's**] lifetime, 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 [You] [the **Covered Person**] and **Your Spouse**, other beneficiaries, and any other person, if in **Our** 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 [You are] [the **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, [You refuse] [the **Covered Person** refuses] this treatment, and [You suffer] [the **Covered Person** suffers] a **Heart Attack**.]
 - ii. [A **Physician** has recommended treatment for a brain aneurysm or carotid artery stenosis, [You refuse] [the **Covered Person** refuses] treatment, and [You suffer] [the **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**, [You refuse] [the **Covered Person** refuses], and [You develop] [the **Covered Person** develops] **Cancer**.]
- If [You are] [the **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** for 12 months following the effective date of this Rider. 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. [Your] [the **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 **[You]** [the **Covered Person**], any irrevocable beneficiary, and any permitted assignees, showing the effect of the **Coverage Amount** payment on the **Policy** when **[You receive]** [the **Covered Person** receives] payment of the **Coverage Amount**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Wellness Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If after this **Policy** has been in force for [six (6)] months, [**You** undergo] [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**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

Effective Date: _____ Attached to and forming a part of **Policy/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. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If **You** become **Unemployed** while covered under this **Policy**, **We** will waive the premium due from **You** 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**, **Your** premium for this **Policy** will be waived until the earliest of the following:

1. **You** are no longer **Unemployed**.
2. the **Policy** terminates.
3. [sixty (60)] days has expired since the Waiver of Premium was granted by **Us**.
4. [**You** attain age [seventy (70)].]

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

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

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

No Claim Discount



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If after the **Policy** has been in force for [three (3)] years, and no claim has been filed or paid under the coverages for this **Policy**, [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 [ten percent (10%)] off the annual premium as stated in the Schedule of the **Policy**. 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.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

If a **Covered Injury** to [You] [a **Covered Person**] [or] [Your covered **Spouse/Domestic Partner**]] results in any of the following **Covered Losses**, **We** will pay the percentage of the **Principal Sum** applicable to that **Covered Person** as shown on the Schedule. The **Covered Loss** must occur within [365] days of the **Covered Accident**.

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

Covered Loss of	Percentage of the Principal Sum
1. Both Hands or Both Feet	[100% of Principal Sum]
2. One Hand and One Foot	[100% of Principal Sum]
3. One Hand or One Foot plus the Loss of Sight of One Eye	[100% of Principal Sum]
4. Sight of Both Eyes	[100% of Principal Sum]
5. Speech and Hearing	[100% of Principal Sum]
6. Speech or Hearing	[50% of Principal Sum]
7. One Hand; One Foot; or Sight of One Eye	[50% of Principal Sum]
8. Thumb and Index Finger on the same Hand	[25% of Principal Sum]
9. [Hearing in One Ear	[25% of Principal Sum]]

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

[Covered Loss of Use of	Percentage of the Principal Sum
1. Four Limbs	[100% of Principal Sum]
2. Three Limbs	[75% of Principal Sum]
3. Two Limbs	[66 2/3% of Principal Sum]
4. One Limb	[50% of Principal Sum]]

[Plegia	Percentage of the Principal Sum
1. Quadriplegia (total paralysis of all four Limbs)	[100% of Principal Sum]
2. [Triplegia (total paralysis of three Limbs)	[75% of Principal Sum]]
3. [Paraplegia (total paralysis of both lower Limbs)	[66 2/3% of Principal Sum]]
4. [Hemiplegia (total paralysis of upper and lower Limbs	

on one side of the body)

[50% of **Principal Sum**]]

5. [Uniplegia (total paralysis of one **Limb**)

[25% of **Principal Sum**]]

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

Covered Loss means:

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

[**Covered Loss** includes [**Covered Loss of Use**] [and] [**Plegia**].]

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

[**Plegia** must [continue for [twelve (12)] consecutive months and] be determined by **Our** competent medical authority to be total, permanent, complete and irreversible paralysis of [one (1)] or more **Limb(s)**. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]

[**Limb** means an entire arm or a leg.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
 Company Tracking Number: CW AH 33365
 TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

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

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
 Company Tracking Number: CW AH 33365
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 11/22/2011	Exhibit I (Premiums)	U-IMC-117-A, U-IMC-119-A, U-IMC-121-A, U-IMC-122-A, U-IMC-125-A, U-IMC-127-A, U-IMC-129-A, U-IMC-130-A, U-IMC-132-A, U-IMC-134-A, U-IMC-136-A, U-IMC-137-A, U-IMC-138-A, U-IMC-140-A, U-IMC-143-A, U-IMC-144-A, U-IMC-145-A, U-IMC-146-A	New		ZNA02.IMC.v1.1.50%.LR.Rates.20110831.pdf

Exhibit I
Zurich American Insurance Company
Accident Insurance Policy U-IMC-100-A et al

Rating Structure with Premiums Based on a 50% Loss Ratio

Table 1a	Accident Medical Expense - Primary Coverage
Table 1b	Accident Medical Expense - Excess Integrated
Table 1c	Accident Medical Expense - Excess Corridor
Table 2	Accident Medical Expense - Out of Country Adjustment
Table 3a	Accident Medical Expense - First Treatment/Service Adjustment (Primary & Excess Integrated)
Table 3b	Accident Medical Expense - First Treatment/Service Adjustment (Excess Corridor)
Table 4a	Accident Medical Expense - Medical Expense Incurred Adjustment (Primary & Excess Integrated)
Table 4b	Accident Medical Expense - Medical Expense Incurred Adjustment (Excess Corridor)
Table 5	Accident Medical Expense - Medical Emergency Care Adjustment
Table 6a	Accident Medical Expense - No Inforce Policy Coinsurance Adjustment (Excess Integrated)
Table 6b	Accident Medical Expense - No Inforce Policy Coinsurance Adjustment (Excess Corridor)
Table 7	Personal Property Benefit
Table 8	Personal Property Benefit - Deductible Adjustment Factor
Table 9	Personal Property Benefit - Maximum Benefit Adjustment Factor
Table 10	Waiver of Premium Due to Loss of Employment Benefit
Table 11	Waiver of Premium Due to Loss of Employment Benefit - Prior Employment Period
Table 12	Wellness Benefit
Table 13	Wellness Benefit - Waiting Period Adjustment
Table 14	Critical Illness Benefit
Table 15	Critical Illness Benefit- Waiting Period Adjustment
Table 16	No Claim Discount Load Factors
Table 17	Accident Weekly Indemnity Benefit
Table 18	Accidental Dismemberment, Loss of Use, and Plegia
Table 19	Maximum Benefit Risk Adjustment Factors
Table 20	Catastrophe Cash Benefit
Table 21	Coma Benefit
Table 22	Emergency Treatment Benefit
Table 23	Funeral Expense Benefit
Table 24	In-Hospital Indemnity Benefit
Table 25	Terrorism Benefit
Table 26	Travel Assistance Plan
Table 27	Accidental Dismemberment, Loss of Use, and Plegia

Premium Calculations Per Person

(1) Accident Medical Expense	[Table 1 Premium] x [Table 2 Factor] x [Table 3 Factor] x [Table 4 Factor] x [Table 5 Factor] x [Table 6 Factor]
(2) Personal Property Benefit	[Table 7 Premium] x [Table 8 Factor] x [Table 9 Factor]
(3) Wellness Benefit	[Table 12 Premium] x [Table 13 Factor]
(3) Critical Illness Benefit	[Table 14 Premium] x [Table 15 Factor] x [Critical Illness Benefit ÷ 1,000]
(4) Accident Weekly Indemnity Benefit	[Table 17 Premium] x [Accident Weekly Indemnity Benefit ÷ 1,000]
(5a) Accidental Dismemberment for Dependent Children	[Table 18 Premium] x [Table 19 Factor] x [Principle Sum ÷ 1,000]
(5b) Loss of Use for Dependent Children	[Table 18 Premium] x [Table 19 Factor] x [Principle Sum ÷ 1,000]
(5c) Plegia for Dependent Children	[Table 18 Premium] x [Table 19 Factor] x [Principle Sum ÷ 1,000]
(6) Catastrophe Cash Benefit	[Table 20 Premium] x [Catastrophe Cash Benefit ÷ 1,000]
(7) Coma Benefit	[Table 21 Premium] x [Coma Benefit ÷ 1,000]
(8) Emergency Treatment Benefit	[Table 22 Premium] x [Emergency Treatment Benefit ÷ 1,000]
(9) Funeral Expense Benefit	[Table 23 Premium] x [Funeral Expense Benefit ÷ 1,000]
(10) In-Hospital Indemnity Benefit	[Table 24 Premium] x [In-Hospital Indemnity Benefit ÷ 100]
(11a) Terrorism Benefit - Accidental Death	[Table 25 Premium] x [Terrorism Benefit ÷ 1,000]
(11b) Terrorism Benefit - All Others	[Table 25 Premium] x [Terrorism Benefit ÷ 1,000]
(12) Travel Assistance Plan	[Table 26 Premium]
(13a) Accidental Dismemberment	[Table 27 Premium] x [Table 19 Factor] x [Principle Sum ÷ 1,000]
(13b) Loss of Use	[Table 27 Premium] x [Table 19 Factor] x [Principle Sum ÷ 1,000]
(13c) Plegia	[Table 27 Premium] x [Table 19 Factor] x [Principle Sum ÷ 1,000]

See "Age Gender Industry" tab for guidance on applying Table 3 and Table 5 adjustment factors

(14) Total Annual Premium Per Person $[(1) + (2) + (3) + (4) + (5a) + (5b) + (5c) + (6) + (7) + (8) + (9) + (10) + (11a) + (11b) + (12) + (13a) + (13b) + (13c)]$
 $\times (1 + [Table 10 Load]) \times [Table 11 Factor] \times (1 + [Table 16 Load])$

(15) Premium Classes

Premiums will vary by family composition. The family composition classes could be any of the following: "Insured", "Insured + Spouse/Domestic Partner", "Insured + Child(ren)", "Insured + Spouse/Domestic Partner and Child(ren)", "Spouse/Domestic Partner", or "Child(ren)". Premiums are calculated separately for the insured, spouse/domestic partner, and child using the appropriate principle sum and then added together to determine the total premium based on the family composition. For family compositions with children, the following assumptions are used:

Premium Tier	Assumed # of Children
Insured + Children	1.63
Insured + Spouse/Domestic Partner + Children	2.05

Exhibit I
Zurich American Insurance Company
[Out of Country] Accident Medical Expense Benefit U-IMC-138-A
Nationwide Annual Premiums

Table 1a
0% Coinsurance

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	69.09	68.24	67.39	65.74	61.20	54.83	49.72	45.58	31.05	20.99
1,500	93.73	92.69	91.67	89.64	83.76	75.77	69.26	63.93	44.60	30.74
2,000	114.67	113.45	112.25	109.87	103.32	94.13	86.54	80.22	57.11	39.57
2,500	133.02	131.68	130.35	127.72	120.60	110.42	102.15	94.98	68.76	48.41
5,000	201.78	200.15	198.52	195.30	186.41	173.75	162.86	153.68	117.17	85.41
7,500	250.19	248.45	246.66	243.14	233.34	219.17	207.13	196.80	154.17	115.65
10,000	287.19	285.34	283.48	279.81	269.58	254.67	241.90	230.84	184.41	140.58
12,500	317.43	315.54	313.67	309.94	299.54	284.29	270.73	258.89	209.34	162.18
15,000	342.36	340.43	338.50	334.67	323.96	308.27	294.71	282.68	230.94	181.15
20,000	382.93	380.93	378.95	374.99	363.89	347.55	333.35	320.87	266.77	213.12
25,000	414.90	412.86	410.83	406.79	395.46	378.74	364.14	351.27	295.52	238.97
50,000	510.59	508.47	506.37	502.19	490.41	472.95	457.61	444.00	383.83	321.30
100,000	594.96	592.81	590.67	586.41	574.42	556.59	540.88	526.91	464.53	398.35
250,000	675.32	673.16	671.00	666.69	654.58	636.55	620.66	606.47	542.92	474.76
500,000	708.15	705.97	703.81	699.50	687.36	669.29	653.34	639.11	575.25	506.62

Table 1a
10% Coinsurance

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	67.47	66.65	65.84	64.24	59.90	53.88	48.92	44.87	30.77	20.91
1,500	90.97	89.96	88.95	86.95	81.59	73.98	67.72	62.56	43.98	30.32
2,000	110.82	109.67	108.51	106.25	100.15	91.42	84.22	78.41	56.11	39.15
2,500	128.07	126.82	125.58	123.12	116.44	107.00	99.00	92.53	67.32	47.52
5,000	192.42	190.91	189.41	186.44	178.24	166.50	156.67	147.97	113.32	83.24
7,500	236.95	235.35	233.75	230.58	221.76	208.84	197.63	187.97	148.31	112.14
10,000	271.13	269.42	267.73	264.38	255.02	241.36	229.62	219.42	176.42	135.81
12,500	298.54	296.79	295.06	291.61	281.97	267.85	255.65	244.98	199.72	156.02
15,000	321.47	319.70	317.93	314.42	304.58	290.12	277.59	266.60	219.65	173.57
20,000	358.27	356.45	354.64	351.04	340.94	326.04	313.07	301.64	252.33	202.73
25,000	386.91	385.06	383.21	379.56	369.28	354.11	340.83	329.11	278.17	226.41
50,000	471.88	469.97	468.07	464.29	453.65	437.88	424.01	411.69	357.15	300.24
100,000	545.81	543.87	541.94	538.11	527.31	511.26	497.13	484.55	428.41	368.51
250,000	613.88	611.92	609.98	606.11	595.21	578.99	564.67	551.91	494.70	433.37
500,000	639.87	637.91	635.97	632.09	621.16	604.89	590.54	577.74	520.27	458.50

Table 1a
20% Coinsurance

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	65.60	64.87	64.15	62.57	58.34	52.54	47.85	44.02	30.49	20.83
1,500	87.84	86.90	85.94	84.04	78.95	71.77	65.89	61.02	43.34	29.90
2,000	106.42	105.35	104.28	102.18	96.48	88.34	81.72	75.98	55.01	38.73
2,500	122.60	121.49	120.38	118.12	111.78	102.97	95.64	89.38	65.75	46.59
5,000	182.25	180.92	179.59	176.94	169.38	158.45	149.20	141.35	109.40	80.87
7,500	222.83	221.37	219.92	217.04	209.00	197.34	187.15	178.30	141.71	107.67
10,000	253.94	252.43	250.93	247.95	239.63	227.43	216.58	207.11	167.47	129.74
12,500	278.69	277.14	275.59	272.53	263.96	251.12	239.98	230.21	188.82	148.44
15,000	299.30	297.72	296.13	292.97	284.09	271.03	259.66	249.67	206.96	164.57
20,000	331.92	330.29	328.66	325.44	316.37	302.99	291.31	281.02	236.41	191.17
25,000	357.48	355.83	354.20	350.95	341.81	328.28	316.31	305.72	259.38	212.36
50,000	431.75	430.05	428.36	425.00	415.55	401.52	389.19	378.18	329.17	277.70
100,000	494.54	492.81	491.09	487.68	478.05	463.73	451.13	439.88	389.68	336.23
250,000	550.76	549.03	547.30	543.86	534.16	519.72	506.99	495.63	444.69	390.02
500,000	571.60	569.85	568.13	564.68	554.97	540.50	527.74	516.37	465.28	410.37

Table 1a
30% Coinsurance

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	63.32	62.60	61.88	60.46	56.55	51.11	46.69	43.00	29.93	20.64
1,500	84.12	83.28	82.41	80.65	75.91	69.25	63.76	59.30	42.34	29.47
2,000	101.37	100.40	99.42	97.52	92.32	84.80	78.57	73.40	53.57	37.83
2,500	116.26	115.23	114.21	112.19	106.56	98.39	91.70	85.91	63.84	45.67
5,000	170.72	169.51	168.29	165.90	159.25	149.50	141.08	133.85	104.50	78.04
7,500	207.41	206.11	204.81	202.24	195.08	184.49	175.36	167.43	134.55	103.20
10,000	234.86	233.51	232.16	229.47	221.98	211.00	201.49	193.20	157.60	123.30
12,500	256.81	255.42	254.04	251.32	243.67	232.43	222.67	214.07	176.70	140.15
15,000	275.08	273.68	272.29	269.51	261.75	250.16	240.08	231.18	192.90	154.65
20,000	303.64	302.20	300.77	297.93	289.94	278.13	267.80	258.70	219.07	178.33
25,000	325.57	324.11	322.66	319.79	311.70	299.74	289.27	280.00	239.12	196.85
50,000	389.11	387.61	386.13	383.18	374.85	362.50	351.64	341.98	299.09	253.74
100,000	441.85	440.33	438.83	435.83	427.39	414.84	403.78	393.91	349.80	302.73
250,000	486.63	485.11	483.60	480.58	472.10	459.45	448.30	438.35	393.73	345.82
500,000	501.67	500.15	498.63	495.61	487.11	474.45	463.28	453.32	408.59	360.50

Exhibit I
Zurich American Insurance Company
[Out of Country] Accident Medical Expense Benefit U-IMC-138-A
Nationwide Annual Premiums

Table 1a
40% Coinsurance

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	60.65	59.97	59.29	57.97	54.39	49.32	45.14	41.71	29.32	20.21
1,500	79.81	79.01	78.21	76.64	72.36	66.25	61.29	56.99	41.26	29.04
2,000	95.62	94.73	93.85	92.12	87.37	80.67	74.93	70.25	51.83	36.90
2,500	109.13	108.22	107.30	105.48	100.42	93.10	87.05	81.78	61.47	44.30
5,000	157.97	156.90	155.84	153.72	147.83	139.22	131.75	125.32	98.87	74.75
7,500	190.46	189.32	188.20	185.97	179.72	170.58	162.43	155.33	125.60	97.31
10,000	214.32	213.13	211.95	209.61	203.05	193.42	185.06	177.73	146.44	115.71
12,500	233.27	232.07	230.88	228.50	221.84	212.05	203.52	195.96	163.14	130.60
15,000	248.94	247.72	246.50	244.08	237.28	227.24	218.48	210.76	177.31	143.38
20,000	273.35	272.10	270.86	268.40	261.46	251.21	242.24	234.29	199.53	163.94
25,000	291.72	290.46	289.21	286.72	279.74	269.39	260.31	252.27	216.68	179.73
50,000	344.57	343.29	342.01	339.47	332.31	321.67	312.32	303.98	266.94	227.60
100,000	387.01	385.71	384.42	381.84	374.60	363.83	354.31	345.84	307.93	267.40
250,000	421.07	419.77	418.47	415.89	408.61	397.76	388.20	379.67	341.39	300.25
500,000	431.61	430.30	429.00	426.42	419.13	408.29	398.71	390.17	351.83	310.58

Table 1a
50% Coinsurance

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	57.33	56.73	56.12	54.94	51.66	47.06	43.27	40.10	28.56	19.79
1,500	74.66	73.96	73.27	71.91	68.10	62.59	58.14	54.26	39.82	28.14
2,000	88.80	88.04	87.27	85.76	81.61	75.62	70.58	66.35	49.75	35.75
2,500	100.89	100.07	99.26	97.65	93.20	86.88	81.43	76.83	58.58	42.71
5,000	143.60	142.67	141.74	139.91	134.78	127.34	120.95	115.43	92.21	70.29
7,500	171.18	170.22	169.25	167.34	161.98	154.13	147.35	141.34	115.47	90.58
10,000	191.47	190.47	189.47	187.50	181.94	173.78	166.67	160.43	133.39	106.56
12,500	207.45	206.43	205.42	203.40	197.73	189.37	182.07	175.64	147.76	119.48
15,000	220.37	219.35	218.32	216.29	210.58	202.15	194.78	188.27	159.62	130.23
20,000	240.30	239.26	238.21	236.14	230.32	221.70	214.13	207.43	177.98	147.38
25,000	255.29	254.24	253.19	251.09	245.21	236.48	228.81	222.00	191.92	160.65
50,000	297.48	296.41	295.34	293.21	287.21	278.30	270.44	263.45	232.26	199.18
100,000	329.90	328.82	327.74	325.59	319.55	310.55	302.63	295.55	263.89	230.00
250,000	354.08	352.99	351.90	349.75	343.68	334.64	326.66	319.55	287.63	253.31
500,000	360.57	359.49	358.40	356.25	350.17	341.13	333.15	326.03	294.08	259.70

Adjustment Factors

Table 2
Out of Country Adjustment

Covered Area	Rate Factor
Includes US Coverage*	1.00
Only Out of Country (Non-U.S.) For Benefit Maximums less than \$50,000	0.65
For Benefit Maximums \$50,000 or more	0.50

*U.S. Coverage varies by area factor; 1.00 is nationwide average
(US State area factors in separate table)

Table 3a
First Treatment/Service within 30, 90, 180, 365 Days of Accident

Time for Loss to Occur	30 Days	90 Days	180 Days	365 Days
Adjustment Factor	0.990	1.000	1.020	1.050

Table 4a
Medical Expenses Incurred within 26, 52, 104 Weeks of Accident

Time for Medical Expense to Occur	26 Weeks	52 Weeks	104 Weeks
Adjustment Factor	0.950	1.000	1.150

Table 5
Medical Emergency Care within 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	24 Hours	48 Hours	72 Hours	96 Hours
Adjustment Factor	0.990	0.995	1.000	1.005

Exhibit I
Zurich American Insurance Company
[Out of Country] Accident Excess Integrated Medical Expense Benefit U-IMC-121-A
Nationwide Annual Premiums

Table 1b

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
1,000	60.98	60.47	59.96	58.90	55.88	51.51	47.70	44.42	31.05	20.99
1,500	73.65	73.13	72.63	71.57	68.55	64.18	60.36	57.09	43.59	30.74
2,000	82.73	82.22	81.71	80.65	77.63	73.26	69.45	66.17	52.68	39.38
2,500	89.83	89.32	88.81	87.75	84.74	80.36	76.55	73.27	59.78	46.49
5,000	111.69	111.18	110.67	109.61	106.60	102.22	98.42	95.13	81.64	68.35
7,500	123.96	123.45	122.94	121.89	118.86	114.50	110.68	107.41	93.91	80.62
10,000	132.15	131.64	131.13	130.07	127.05	122.68	118.87	115.60	102.10	88.80
12,500	138.17	137.66	137.15	136.09	133.07	128.70	124.88	121.61	108.11	94.82
15,000	142.84	142.34	141.83	140.77	137.75	133.38	129.56	126.29	112.79	99.50
20,000	149.69	149.18	148.67	147.61	144.59	140.22	136.41	133.14	119.64	106.34
25,000	154.44	153.93	153.42	152.36	149.35	144.97	141.16	137.88	124.38	111.10
50,000	166.08	165.57	165.07	164.01	160.98	156.62	152.80	149.53	136.03	122.74
100,000	172.72	172.22	171.71	170.65	167.63	163.26	159.44	156.17	142.67	129.38
250,000	175.87	175.37	174.85	173.79	170.78	166.41	162.59	159.32	145.82	132.53
500,000	176.22	175.71	175.20	174.14	171.13	166.75	162.94	159.66	146.16	132.88

Adjustment Factors

Table 2

Out of Country Adjustment

Covered Area	Rate Factor
Includes US Coverage*	1.00
Only Out of Country (Non-U.S.) For Benefit Maximums less than \$50,000	0.65
For Benefit Maximums \$50,000 or more	0.50

*U.S. Coverage varies by area factor; 1.00 is nationwide average
(US State area factors in separate table)

Table 3a

First Treatment/Service within 30, 90, 180, 365 Days of Accident

Time for Loss to Occur	30 Days	90 Days	180 Days	365 Days
Adjustment Factor	0.990	1.000	1.020	1.050

Table 4a

Medical Expenses Incurred within 26, 52, 104 Weeks of Accident

Time for Medical Expense to Occur	26 Weeks	52 Weeks	104 Weeks
Adjustment Factor	0.950	1.000	1.150

Table 5

Medical Emergency Care within 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	24 Hours	48 Hours	72 Hours	96 Hours
Adjustment Factor	0.990	0.995	1.000	1.005

Table 6a

No Inforce Policy Coinsurance Adjustment

Maximum Benefit	Insured Coinsurance				
	50%	40%	30%	20%	10%
1,000	1.00	1.04	1.06	1.09	1.11
1,500	1.00	1.04	1.08	1.11	1.14
2,000	1.00	1.05	1.09	1.13	1.16
2,500	1.00	1.05	1.10	1.14	1.18
5,000	1.00	1.07	1.14	1.19	1.24
7,500	1.00	1.09	1.16	1.22	1.28
10,000	1.00	1.09	1.17	1.25	1.31
12,500	1.00	1.10	1.19	1.27	1.34
15,000	1.00	1.10	1.19	1.28	1.36
20,000	1.00	1.11	1.21	1.30	1.39
25,000	1.00	1.12	1.22	1.32	1.41
50,000	1.00	1.13	1.25	1.37	1.48
100,000	1.00	1.15	1.29	1.42	1.55
250,000	1.00	1.16	1.32	1.47	1.63
500,000	1.00	1.17	1.34	1.50	1.66

Exhibit I
Zurich American Insurance Company
[Out of Country] Accident Excess Corridor Medical Expense Benefit U-IMC-122-A
Annual Premiums

Table 1c

Maximum Benefit	Deductible									
	0	25	50	100	250	500	750	1,000	2,500	5,000
250	20.81	20.55	20.27	19.67	18.09	13.13	8.95	6.94	3.02	1.54
500	38.89	38.36	37.74	36.28	31.22	22.09	15.89	12.67	5.92	2.95
750	52.03	50.90	49.70	47.29	40.17	29.03	21.62	17.52	8.33	4.32
1,000	60.98	59.59	58.17	55.28	47.12	34.75	26.48	21.75	10.72	5.63
1,500	73.65	71.97	70.31	67.01	57.70	43.83	34.44	28.85	14.90	8.06
2,000	82.73	80.94	79.16	75.64	65.66	50.93	40.82	34.78	18.58	10.28
2,500	89.83	87.97	86.12	82.45	72.05	56.86	46.13	39.57	21.86	12.28
5,000	111.69	109.67	107.65	103.65	92.42	75.74	63.98	56.33	34.14	20.46
7,500	123.96	121.89	119.82	115.70	104.16	87.00	74.71	66.59	42.32	26.48
10,000	132.15	130.04	127.94	123.79	112.05	94.59	82.08	73.76	48.34	31.16
12,500	138.17	136.04	133.93	129.74	117.91	100.38	87.71	79.21	53.02	34.91
15,000	142.84	140.71	138.58	134.37	122.48	104.81	92.03	83.45	56.77	38.00
20,000	149.69	147.54	145.40	141.15	129.15	111.32	98.44	89.75	62.45	42.75
25,000	154.44	152.28	150.13	145.86	133.83	115.94	103.00	94.24	66.56	46.30
50,000	166.08	163.91	161.75	157.46	145.34	127.31	114.24	105.35	76.86	55.61
100,000	172.72	170.55	168.38	164.08	151.93	133.86	120.74	111.80	83.03	61.29
250,000	175.87	173.69	171.52	167.22	155.07	136.99	123.85	114.90	86.07	64.23
500,000	176.22	174.04	171.87	167.56	155.41	137.32	124.19	115.25	86.39	64.53
1,000,000	176.22	174.04	171.87	167.56	155.41	137.32	124.19	115.25	86.39	64.53
2,000,000	176.22	174.04	171.87	167.56	155.41	137.32	124.19	115.25	86.39	64.53

Adjustment Factors

Table 2
Out of Country Adjustment

Covered Area	Rate Factor
Includes US Coverage*	1.00
Only Out of Country (Non-U.S.)	
For Benefit Maximums less than \$50,000	0.65
For Benefit Maximums \$50,000 or more	0.50

*U.S. Coverage varies by area factor; 1.00 is nationwide average
(US State area factors in separate table)

Table 3b
First Treatment/Service within 30, 90, 180, 365 Days of Accident

Time for Loss to Occur	30 Days	90 Days	180 Days	365 Days	730 Days	1,825 Days
Adjustment Factor	0.990	1.000	1.020	1.050	1.100	1.300

Table 4b
Medical Expenses Incurred within 26, 52, 104, 156, 260 Weeks of Accident

Time for Medical Expense to Occur	4 Weeks	26 Weeks	52 Weeks	104 Weeks	156 Weeks	260 Weeks	520 Weeks
Adjustment Factor	0.910	0.950	1.000	1.150	1.200	1.300	1.600

Table 5
Medical Emergency Care within 24, 48, 72, 96 hours of Accident

Time for Loss to Occur	24 Hours	48 Hours	72 Hours
Adjustment Factor	0.990	0.995	1.000

Table 6b
No Inforce Policy Coinsurance Adjustment

Maximum Benefit	Insured Coinsurance			
	50%	40%	30%	20%
250	1.00	1.04	1.07	1.09
500	1.00	1.04	1.07	1.09
750	1.00	1.04	1.07	1.09
1,000	1.00	1.04	1.07	1.09
1,500	1.00	1.05	1.09	1.12
2,000	1.00	1.05	1.10	1.14
2,500	1.00	1.06	1.11	1.15
5,000	1.00	1.08	1.15	1.20
7,500	1.00	1.09	1.17	1.24
10,000	1.00	1.10	1.18	1.26
12,500	1.00	1.10	1.19	1.28
15,000	1.00	1.11	1.20	1.29
20,000	1.00	1.11	1.22	1.31
25,000	1.00	1.12	1.23	1.33
50,000	1.00	1.14	1.26	1.38
100,000	1.00	1.15	1.29	1.43
250,000	1.00	1.17	1.33	1.49
500,000	1.00	1.17	1.34	1.52
1,000,000	1.00	1.17	1.34	1.52
2,000,000	1.00	1.17	1.34	1.52

Exhibit I
 Zurich American Insurance Company
 Personal Property Benefit U-IMC-134-A
 Annual Premiums

Table 7

Benefit	Unit	Annual Premium per Unit
Personal Property Benefit	Per Person	\$10.55

Adjustment Factors

Table 8

Deductible	Factor
\$0	1.00
\$50	0.90
\$100	0.80
\$150	0.70
\$200	0.60
\$250	0.50

Table 9

Maximum	Factor
\$50	0.10
\$250	0.50
\$500	1.00
\$1,000	1.50
\$2,500	2.25
\$5,000	3.50

Exhibit I
 Zurich American Insurance Company
 Waiver of Premium Due to Loss of Employment Benefit U-IMC-144-A
 Annual Premium Rate Load Factors*

Table 10

Days Waived	Days Unemployed Before Benefits Paid			
	90	120	150	180
30	0.0020	0.0017	0.0014	0.0012
60	0.0037	0.0032	0.0026	0.0023
90	0.0052	0.0044	0.0037	0.0033
120	0.0064	0.0055	0.0048	0.0042
150	0.0075	0.0065	0.0057	0.0050
180	0.0085	0.0074	0.0065	0.0057

* Load factors should be multiplied by the total premium of all benefits covered by the waiver of premium due to loss of employment rider and the factor for required prior employment period days.

Table 11

Prior Employment Period	
Days	Factor
90	1.020
120	1.010
150	1.004
180	1.000

Exhibit I
 Zurich American Insurance Company
 Wellness Benefit U-IMC-143-A
 Annual Premiums

Table 12

Benefit	Tier	Unit	Annual Premium per Unit
Wellness Benefit	Insured Only	\$50, Max 1 Test	\$26.93
	Spouse Only	\$50, Max 1 Test	\$26.93
	Child Only	\$50, Max 1 Test	\$20.14
	Insured + Spouse	\$50, Max 2 Tests	\$53.85
	Insured + Child(ren)	\$50, Max 2 Tests	\$36.66
	Family	\$50, Max 2 Tests	\$68.20

Adjustment Factors

Table 13

Waiting Period	Factor
1 Month	1.14
2 Months	1.11
3 Months	1.08
4 Months	1.05
5 Months	1.03
6 Months	1.00

Exhibit I
Zurich American Insurance Company
Critical Illness Coverage U-IMC-140-A
Annual Premiums

Table 14a

Benefit	Attained Age	Unit	Annual Premium per Unit							Total
			Cancer	Heart Attack	Kidney Failure	Loss of Limbs	Major Organ Transplant	Paralysis	Stroke	
Critical Illness	<18	1,000	0.19	0.11	0.02	0.08	0.11	0.03	0.02	0.56
	18	1,000	0.36	0.11	0.05	0.08	0.13	0.08	0.02	0.83
	19	1,000	0.40	0.11	0.05	0.08	0.14	0.08	0.02	0.88
	20	1,000	0.43	0.11	0.06	0.08	0.14	0.09	0.02	0.93
	21	1,000	0.47	0.13	0.07	0.08	0.15	0.09	0.03	1.02
	22	1,000	0.51	0.15	0.07	0.08	0.15	0.09	0.04	1.09
	23	1,000	0.57	0.17	0.08	0.08	0.15	0.08	0.04	1.17
	24	1,000	0.63	0.19	0.08	0.08	0.15	0.08	0.05	1.26
	25	1,000	0.70	0.21	0.09	0.08	0.15	0.08	0.06	1.37
	26	1,000	0.76	0.23	0.10	0.08	0.15	0.08	0.07	1.47
	27	1,000	0.83	0.25	0.11	0.08	0.14	0.07	0.07	1.55
	28	1,000	0.92	0.27	0.12	0.08	0.14	0.07	0.08	1.68
	29	1,000	1.01	0.29	0.13	0.08	0.14	0.07	0.09	1.81
	30	1,000	1.10	0.31	0.15	0.08	0.16	0.06	0.10	1.96
	31	1,000	1.20	0.39	0.16	0.08	0.17	0.06	0.15	2.21
	32	1,000	1.29	0.47	0.17	0.08	0.19	0.06	0.21	2.47
	33	1,000	1.44	0.55	0.18	0.08	0.20	0.05	0.27	2.77
	34	1,000	1.59	0.63	0.19	0.08	0.22	0.05	0.33	3.09
	35	1,000	1.73	0.72	0.20	0.08	0.23	0.05	0.38	3.39
	36	1,000	1.88	0.80	0.22	0.08	0.25	0.05	0.44	3.72
	37	1,000	2.03	0.88	0.24	0.08	0.27	0.05	0.50	4.05
	38	1,000	2.31	0.96	0.26	0.08	0.28	0.05	0.56	4.50
	39	1,000	2.59	1.05	0.28	0.08	0.30	0.06	0.61	4.97
	40	1,000	2.87	1.13	0.30	0.08	0.31	0.06	0.67	5.42
	41	1,000	3.15	1.36	0.32	0.08	0.32	0.06	0.84	6.13
	42	1,000	3.43	1.59	0.34	0.08	0.33	0.07	1.01	6.85
	43	1,000	3.87	1.83	0.36	0.08	0.34	0.07	1.19	7.74
	44	1,000	4.32	2.06	0.38	0.09	0.35	0.08	1.36	8.64
	45	1,000	4.77	2.29	0.40	0.09	0.36	0.08	1.53	9.52
	46	1,000	5.22	2.53	0.45	0.09	0.38	0.09	1.70	10.46
	47	1,000	5.66	2.76	0.50	0.09	0.39	0.09	1.87	11.36
	48	1,000	6.40	2.99	0.55	0.09	0.40	0.10	2.04	12.57
	49	1,000	7.14	3.22	0.59	0.09	0.41	0.10	2.21	13.76
	50	1,000	7.88	3.46	0.64	0.09	0.45	0.10	2.39	15.01
	51	1,000	8.56	3.84	0.69	0.09	0.49	0.11	2.59	16.37
	52	1,000	9.24	4.22	0.74	0.09	0.53	0.11	2.79	17.72
	53	1,000	10.31	4.61	0.79	0.09	0.57	0.12	2.99	19.48
	54	1,000	11.38	4.99	0.84	0.09	0.61	0.13	3.19	21.23
	55	1,000	12.45	5.38	0.89	0.09	0.64	0.13	3.39	22.97
	56	1,000	13.51	5.75	0.98	0.09	0.68	0.13	3.60	24.74
	57	1,000	14.57	6.13	1.07	0.09	0.72	0.13	3.80	26.51
	58	1,000	16.13	6.50	1.15	0.09	0.72	0.14	4.00	28.73
	59	1,000	17.68	6.88	1.24	0.09	0.72	0.14	4.20	30.95
	60	1,000	19.23	7.25	1.33	0.09	0.72	0.14	4.40	33.16
	61	1,000	20.78	7.73	1.41	0.09	0.72	0.14	4.92	35.79
	62	1,000	22.32	8.21	1.50	0.09	0.72	0.15	5.45	38.44
	63	1,000	24.05	8.69	1.61	0.09	0.65	0.15	5.97	41.21
	64	1,000	25.78	9.17	1.71	0.09	0.57	0.15	6.49	43.96
	65	1,000	27.50	9.64	1.82	0.09	0.50	0.16	7.01	46.72
	66	1,000	29.22	10.12	1.92	0.09	0.42	0.16	7.53	49.46
	67	1,000	30.93	10.59	2.03	0.09	0.35	0.16	8.05	52.20
	68	1,000	32.72	11.06	2.10	0.09	0.27	0.17	8.58	54.99
	69	1,000	34.50	11.53	2.18	0.09	0.20	0.17	9.10	57.77
	70	1,000	36.28	12.00	2.26	0.09	0.20	0.17	9.62	60.62
	71	1,000	38.06	12.89	2.34	0.09	0.20	0.21	11.61	65.40
	72	1,000	39.83	13.77	2.42	0.09	0.20	0.24	13.60	70.15
	73	1,000	40.87	14.65	2.49	0.09	0.20	0.28	15.60	74.18
	74	1,000	41.90	15.52	2.57	0.09	0.20	0.31	17.59	78.18
	75	1,000	42.94	16.39	2.65	0.09	0.20	0.35	19.58	82.20
	76	1,000	44.04	17.27	2.63	0.09	0.20	0.38	21.57	86.18
	77	1,000	45.13	18.13	2.62	0.09	0.20	0.42	23.57	90.16
	78	1,000	45.21	19.00	2.60	0.09	0.20	0.45	25.56	93.11
	79	1,000	45.28	19.86	2.59	0.09	0.20	0.49	27.55	96.06
	80	1,000	45.36	20.73	2.57	0.09	0.20	0.52	29.54	99.01
	81	1,000	45.43	20.73	2.56	0.09	0.20	0.52	29.54	99.07
	82	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	83	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	84	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	85	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	86	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	87	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	88	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13
	89	1,000	45.51	20.73	2.54	0.09	0.20	0.52	29.54	99.13

Rates may be quoted on an age-specific basis or may be quoted on an age-banded or composite basis to reflect the expected demographics of specific groups or markets.

Adjustment Factors

Table 15

Waiting Period	Factor
30 Days	1.14
60 Days	1.11
90 Days	1.08
120 Days	1.05
150 Days	1.03
180 Days	1.00

Exhibit I
 Zurich American Insurance Company
 Critical Illness Coverage U-GMC-140-A
 Annual Premiums

Table 14b

Benefit	Age Band	Unit	Annual Premium per Unit							Total
			Cancer	Heart Attack	Kidney Failure	Loss of Limbs	Major Organ Transplant	Paralysis	Stroke	
Critical Illness	<18	1,000	\$0.19	\$0.11	\$0.02	\$0.08	\$0.11	\$0.03	\$0.02	\$0.56
	18-24	1,000	\$0.51	\$0.15	\$0.07	\$0.08	\$0.15	\$0.09	\$0.04	\$1.09
	25-29	1,000	\$0.83	\$0.25	\$0.11	\$0.08	\$0.14	\$0.07	\$0.07	\$1.55
	30-34	1,000	\$1.29	\$0.47	\$0.17	\$0.08	\$0.19	\$0.06	\$0.21	\$2.47
	35-39	1,000	\$2.03	\$0.88	\$0.24	\$0.08	\$0.27	\$0.05	\$0.50	\$4.05
	40-44	1,000	\$3.43	\$1.59	\$0.34	\$0.08	\$0.33	\$0.07	\$1.01	\$6.85
	45-49	1,000	\$5.66	\$2.76	\$0.50	\$0.09	\$0.39	\$0.09	\$1.87	\$11.36
	50-54	1,000	\$9.24	\$4.22	\$0.74	\$0.09	\$0.53	\$0.11	\$2.79	\$17.72
	55-59	1,000	\$14.57	\$6.13	\$1.07	\$0.09	\$0.72	\$0.13	\$3.80	\$26.51
	60-64	1,000	\$22.32	\$8.21	\$1.50	\$0.09	\$0.72	\$0.15	\$5.45	\$38.44
	65-69	1,000	\$30.93	\$10.59	\$2.03	\$0.09	\$0.35	\$0.16	\$8.05	\$52.20
	70-74	1,000	\$39.83	\$13.77	\$2.42	\$0.09	\$0.20	\$0.24	\$13.60	\$70.15
	75-79	1,000	\$45.13	\$18.13	\$2.62	\$0.09	\$0.20	\$0.42	\$23.57	\$90.16
	80-84	1,000	\$45.51	\$20.73	\$2.54	\$0.09	\$0.20	\$0.52	\$29.54	\$99.13
	85-89	1,000	\$45.51	\$20.73	\$2.54	\$0.09	\$0.20	\$0.52	\$29.54	\$99.13

Adjustment Factors

Table 15

Waiting Period	Factor
30 Days	1.14
60 Days	1.11
90 Days	1.08
120 Days	1.05
150 Days	1.03
180 Days	1.00

Exhibit I
 Zurich American Insurance Company
 No Claim Discount U-IMC-145-A
 Annual Premium Rate Load Factors*

Table 16

Premium Reduction	Number of Years Claims Free to Qualify for Bonus				
	1 Year	2 Year	3 Year	4 Year	5 Year
5%	0.0126	0.0069	0.0043	0.0027	0.0017
10%	0.0252	0.0138	0.0087	0.0055	0.0034
15%	0.0379	0.0207	0.0130	0.0082	0.0052
20%	0.0505	0.0276	0.0174	0.0110	0.0069

* Load factors should be multiplied by the total premium of all benefits covered by the No Claim Discount rider.

Exhibit I
 Zurich American Insurance Company
 Accident Weekly Indemnity Benefit U-IMC-117-A
 Annual Premium per \$1,000 Weekly Benefit

Table 17

Benefit Waiting Period (in Days)	Benefit Period (in Weeks)						
	4	26	52	104	156	208	260
0	220.46	517.27	626.34	760.33	866.33	958.51	1,041.11
3	197.17	471.71	572.91	697.56	796.36	882.36	959.46
7	163.62	413.23	512.83	637.07	735.84	821.80	898.89
30	55.87	172.96	230.01	304.67	365.01	417.75	465.15
60	36.41	128.10	181.17	253.86	313.39	365.55	412.48
90	13.58	58.34	88.61	132.41	169.00	201.27	230.39
180	7.93	39.58	66.22	108.76	145.14	177.45	206.72
365	4.34	25.26	46.52	83.90	116.64	146.07	166.91

Exhibit I
 Zurich American Insurance Company
 Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children U-IMC
 Annual Premiums

Table 18

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Accidental Dismemberment	\$1,000	Varies**	3.75%	\$0.02400
Loss of Use	\$1,000	Varies***	1.73%	\$0.01107
Plegia	\$1,000	Varies****	1.96%	\$0.01254

*Pro-Rate for Other Maximum Benefits

**Accidental Dismemberment: Covered Loss	Percent of Principle Sum
Both Hands or Both Feet	50%
One Hand and One Foot	50%
One Hand or One Foot plus the loss of Sight of One Eye	50%
Sight of Both Eyes	50%
Speech and Hearing	50%
Speech or Hearing	25%
One Hand; One Foot; or Sight of One Eye	25%
Thumb and Index Finger of the same Hand	12.5%
Hearing in One Ear	12.5%

***Loss of Used: Covered Loss	Percent of Principle Sum
4 Limbs	50%
3 Limbs	37.5%
2 Limbs	33.3%
1 Limb	25%

****Plegia: Covered Loss	Percent of Principle Sum
Quadriplegia	50%
Triplegia	37.5%
Paraplegia	33.3%
Hemiplegia	25%
Uniplegia	12.5%

Exhibit I
 Zurich American Insurance Company
 Catastrophe Cash Benefit U-IMC-125-A
 Annual Premiums

Table 20
 Annual Premiums per \$1,000 Lump Sum; and per \$1,000 Monthly Benefit

Waiting Period (in Months)	Lump Sum Benefit	Monthly Payment Benefit Benefit Period (in Weeks)					
		3	12	24	48	60	Lifetime
3	0.16794	0.48468	1.83252	3.46954	6.39394	7.72352	19.27059
6	0.16341	0.46494	1.76848	3.36666	6.23667	7.54414	18.75765
12	0.15465	0.43203	1.66632	3.19636	5.96450	7.22929	17.79372
24	0.14582	0.39181	1.52442	2.94620	5.54196	6.73246	16.08495

For the Initial Lump Sum then Monthly Benefit, add the Lump Sum and Monthly Payment Benefits above.

Exhibit I
Zurich American Insurance Company
Coma Benefit U-IMC-127-A
Annual Premiums

Table 21

Annual Premiums, per \$1,000 Monthly Benefit

Benefit Period (Months)	Annual Premium per \$1,000	Benefit Period (Months)	Annual Premium per \$1,000
1	0.1424	51	5.6806
2	0.2828	52	5.7734
3	0.4211	53	5.8657
4	0.5575	54	5.9575
5	0.6919	55	6.0488
6	0.8244	56	6.1397
7	0.9549	57	6.2301
8	1.0836	58	6.3200
9	1.2104	59	6.4095
10	1.3353	60	6.4985
11	1.4585	61	6.5870
12	1.5805	62	6.6751
13	1.7014	63	6.7628
14	1.8213	64	6.8500
15	1.9401	65	6.9368
16	2.0578	66	7.0231
17	2.1745	67	7.1090
18	2.2902	68	7.1945
19	2.4048	69	7.2796
20	2.5184	70	7.3642
21	2.6310	71	7.4484
22	2.7426	72	7.5322
23	2.8532	73	7.6155
24	2.9631	74	7.6985
25	3.0723	75	7.7811
26	3.1807	76	7.8633
27	3.2884	77	7.9451
28	3.3954	78	8.0265
29	3.5016	79	8.1075
30	3.6072	80	8.1881
31	3.7121	81	8.2683
32	3.8162	82	8.3482
33	3.9197	83	8.4277
34	4.0225	84	8.5067
35	4.1246	85	8.5854
36	4.2261	86	8.6638
37	4.3270	87	8.7417
38	4.4273	88	8.8193
39	4.5271	89	8.8965
40	4.6263	90	8.9733
41	4.7249	91	9.0498
42	4.8229	92	9.1259
43	4.9204	93	9.2016
44	5.0173	94	9.2770
45	5.1136	95	9.3520
46	5.2094	96	9.4267
47	5.3046	97	9.5010
48	5.3993	98	9.5749
49	5.4936	99	9.6485
50	5.5873	100	9.7217

Annual Premiums, per \$1,000 Lump Sum

Waiting Period (Months)	Annual Premium per \$1,000
12	0.1268
13	0.1260
14	0.1252
15	0.1244
16	0.1236
17	0.1228
18	0.1220
19	0.1212
20	0.1204
21	0.1196
22	0.1189
23	0.1181
24	0.1174
25	0.1169

For Monthly Benefit followed by a Lump Sum Benefit, add the Lump Sum and Monthly Benefits above.

Exhibit I
Zurich American Insurance Company
Emergency Treatment Benefit U-IMC-129-A
Annual Premiums

Table 22

Benefit	Unit	Annual Premium per Unit
Emergency Treatment Benefit	\$1,000	\$139.40

Exhibit I
Zurich American Insurance Company
Funeral Expense Benefit U-IMC-130-A
Annual Premiums

Table 23

Benefit	Unit	Annual Premium per Unit
Funeral Expense Benefit	\$1,000	\$0.64000

Exhibit I
 Zurich American Insurance Company
 In-Hospital Indemnity Benefit U-IMC-132-A
 Annual Premiums

Table 24

Waiting Period (Days)	Annual Premiums per \$100 daily benefit
0	15.2508
1	11.0102
2	6.7506
3	3.9707
4	2.4421
5	1.6283
6	1.1352
7	0.7978
8	0.5889
9	0.4535
10	0.3561
11	0.2870
12	0.2369
13	0.1968
14	0.1622
15	0.1379
16	0.1181
17	0.1024
18	0.0894
19	0.0790
20	0.0669
21	0.0548
22	0.0427
23	0.0393
24	0.0358
25	0.0323
26	0.0288
27	0.0253
28	0.0235
29	0.0217
30	0.0199

Exhibit I
Zurich American Insurance Company
Terrorism Benefit U-IMC-136-A
Annual Premiums

Table 25

Benefit	Unit	Annual Premium Inside US	Annual Premium Outside US
Accidental Death	\$1,000	\$0.00418	\$0.04180
All Other Covered Injuries	\$1,000	\$0.01686	\$0.16860

Exhibit I
Zurich American Insurance Company
Travel Assistance Plan U-IMC-137-A
Annual Premiums

Table 26

Benefit	Annual Premium*
Travel Assistance Plan	\$3.16

*Based on \$5,000 maximum benefit. Prorate for other maximum benefits.

Exhibit I
 Zurich American Insurance Company
 Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage U-IMC-146-A
 Annual Premiums

Table 27

Benefit	Unit of Principle Sum	Percent of Principle Sum	Percent of Accidental Death Rate*	Annual Premium per Unit
Accidental Dismemberment	\$1,000	Varies**	7.50%	\$0.04800
Loss of Use	\$1,000	Varies***	3.45%	\$0.02208
Plegia	\$1,000	Varies****	3.92%	\$0.02509

*Pro-Rate for Other Maximum Benefits

**Accidental Dismemberment: Covered Loss	Percent of Principle Sum
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Hand or One Foot plus the loss of Sight of One Eye	100%
Sight of Both Eyes	100%
Speech and Hearing	100%
Speech or Hearing	50%
One Hand; One Foot; or Sight of One Eye	50%
Thumb and Index Finger of the same Hand	25%
Hearing in One Ear	25%

***Loss of Used: Covered Loss	Percent of Principle Sum
4 Limbs	100%
3 Limbs	75.0%
2 Limbs	66.7%
1 Limb	50%

****Plegia: Covered Loss	Percent of Principle Sum
Quadriplegia	100%
Triplegia	75.0%
Paraplegia	66.7%
Hemiplegia	50.0%
Uniplegia	25%

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
 Company Tracking Number: CW AH 33365
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	11/22/2011
Comments:		
Attachment: U-IMC-100 Certificate of Readability-AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	11/22/2011
Comments: The application U-IMC-101-B is attached to the forms schedule		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved	11/22/2011
Comments:		
Attachment: ZNA02.IMC.v1.1.50%.ActMemo.20110831.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved	11/22/2011
Comments: Outline of Coverages U-IMC-103-A AR (08/09) was filed and approved in the product filing, in State Tracking Number: 44259.		

	Item Status:	Status Date:
Satisfied - Item: Explanatory	Approved	11/22/2011
Comments:		

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
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 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Attachment:

U-IMC-1.1 Explanatory Memorandum.pdf

	Item Status:	Status Date:
Satisfied - Item: Statement of Variables	Approved	11/22/2011

Comments:

Attached SOV

Attachment:

U-IMC-1001-A AR - Statement of Variables.pdf

	Item Status:	Status Date:
Satisfied - Item: 11-17-11 response - redlined forms	Approved	11/22/2011

Comments:

Attachments:

U-IMC-132-A AR - In-Hospital Indemnity Benefit.RED.pdf

U-IMC-138-A AR - AME Primary.RED.pdf

U-IMC-140-A AR - Critical Illness Coverage.RED.pdf

Certificate of Readability for Arkansas



Zurich American Insurance Company

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

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

Form Number	Title	Flesch Score
U-IMC-101-B AR (05/11)	Application	49
U-IMC-117-A AR (05/11)	Accident [Weekly] Indemnity Benefit	36
U-IMC-119-A CW (05/11)	Accident Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children	59
U-IMC-121-A AR (05/11)	[Out of Country] Accident Excess Integrated Medical Expense Benefit	38
U-IMC-122-A AR (05/11)	[Out of Country] Accident Medical Expense Excess Corridor Benefit	38
U-IMC-125-A AR (05/11)	Catastrophe Cash Benefit	46
U-IMC-127-A AR (05/11)	Coma Benefit	54
U-IMC-129-A CW (05/11)	Emergency Treatment Benefit	44
U-IMC-130-A CW (05/11)	Funeral Expense Benefit	54
U-IMC-132-A AR (05/11)	In-Hospital Indemnity Benefit	47
U-IMC-134-A CW (05/11)	Personal Property Benefit	34
U-IMC-136-A CW (05/11)	Terrorism Benefit	47
U-IMC-137-A CW (05/11)	Travel Assistance Coverage	44
U-IMC-138-A AR (05/11)	[Out of Country] Accident Medical Expense Benefit	37
U-IMC-140-A AR (05/11)	Critical Illness Coverage	41
U-IMC-143-A CW (05/11)	Wellness Benefit	42
U-IMC-144-A CW (05/11)	Waiver of Premium Due to Loss of Employment Benefit	50
U-IMC-145-A CW (05/11)	No Claim Discount Benefit	63
U-IMC-146-A CW (05/11)	Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage	58

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

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

Signature: 

Officer: Lisa Plante

Title: Head of A&H Product Management

Date: June 10, 2011



Zurich American Insurance Company

**EXPLANATORY MEMORANDUM
Individual Accident Insurance Policy Riders
Company Filing Number – CW AH 33365
U-IMC-100-A (08/09), et al**

Attached for your review are new forms for which we are seeking your approval to use with the Individual Accident Insurance product previously approved by your Department

The Individual Accident Policy and these riders may be marketed through brokers, consultants, third party administrators, financial institutions and sales employees.

All forms are new except Application U-IMC-101-B replaces U-IMC-101-A (the application was revised to add these additional riders).

The Individual 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.

Variable data is bracketed. Amounts may vary and some provisions may be omitted depending upon the Individual's needs. Variable data will never exclude or limit provisions required by the jurisdiction in which the Policy is issued. A detailed explanation of all variable data is included.

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

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

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. [or **Domestic Partner**] will always be in or out.

APPLICATION – U-IMC-101-B AR (05/11)

APPLICANT INFORMATION [Last 4 Digits of SSN: XXX-XX-]	This will be in or out.																																
[SPOUSE [or DOMESTIC PARTNER] INFORMATION (if Applicant is applying for Dependent coverage) Full Legal Name (First, Middle Initial and Last): Date of Birth:]	This entire section will be in or out.																																
[DEPENDENT CHILD(REN) INFORMATION (if Applicant is applying for Dependent coverage) [If you wish to add more Dependent Child(ren), please attach a separate sheet of paper and include all the information requested.] Full Legal Name (First, Middle Initial and Last): Date of Birth: Full Legal Name (First, Middle Initial and Last): Date of Birth: [Full Legal Name (First, Middle Initial and Last): Date of Birth:] [Full Legal Name (First, Middle Initial and Last): Date of Birth:]]	This entire section will be in or out. If in: This statement will be in or out; This will be in or out; and This will be in or out.																																
INSURANCE REQUESTED <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Plan Selected</td> <td style="width: 50%;">Principal Sum</td> </tr> <tr> <td><input type="checkbox"/> plus Spouse [or Domestic Partner] Only] [as per the Policy Schedule]</td> <td>This will be in or out.</td> </tr> <tr> <td><input type="checkbox"/> plus Dependent Child(ren) Only] [as per the Policy Schedule]</td> <td>This will be in or out.</td> </tr> <tr> <td><input type="checkbox"/> plus Spouse [or Domestic Partner] and Dependent Child(ren)] [as per the Policy Schedule]</td> <td>This will be in or out.</td> </tr> </table> <p>[The Principal Sum for Covered Dependents will be a percentage of the Applicant's Principal Sum.]</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">[Coverage(s) Included:</td> <td style="width: 50%;">Coverage Amount</td> </tr> <tr> <td>[Accidental Death Coverage]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Dismemberment Coverage]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Exposure and Disappearance Coverage]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td>[Critical Illness Coverage [for:]</td> <td>[as per the Policy Schedule]</td> </tr> <tr> <td> [Cancer/Cancerous]</td> <td></td> </tr> <tr> <td> [Heart Attack (Myocardial Infarction)]</td> <td></td> </tr> <tr> <td> [Kidney Failure]</td> <td></td> </tr> <tr> <td> [Loss of Limb(s)]</td> <td></td> </tr> <tr> <td> [Major Organ Transplant]</td> <td></td> </tr> <tr> <td> [Paralysis]</td> <td></td> </tr> <tr> <td> [Stroke (Cerebrovascular Accident)]]</td> <td></td> </tr> </table>	Plan Selected	Principal Sum	<input type="checkbox"/> plus Spouse [or Domestic Partner] Only] [as per the Policy Schedule]	This will be in or out.	<input type="checkbox"/> plus Dependent Child(ren) Only] [as per the Policy Schedule]	This will be in or out.	<input type="checkbox"/> plus Spouse [or Domestic Partner] and Dependent Child(ren)] [as per the Policy Schedule]	This will be in or out.	[Coverage(s) Included:	Coverage Amount	[Accidental Death Coverage]	[as per the Policy Schedule]	[Dismemberment Coverage]	[as per the Policy Schedule]	[Exposure and Disappearance Coverage]	[as per the Policy Schedule]	[Critical Illness Coverage [for:]	[as per the Policy Schedule]	[Cancer/Cancerous]		[Heart Attack (Myocardial Infarction)]		[Kidney Failure]		[Loss of Limb(s)]		[Major Organ Transplant]		[Paralysis]		[Stroke (Cerebrovascular Accident)]]		This will be in or out. This entire section will be in or out. If in: Any combination of Coverages may be in or out; If in, any combination of Covered Conditions may be in or out;
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[]	[as per the Policy Schedule]																																																						
<p>[CRITICAL ILLNESS COVERAGE QUESTIONNAIRE</p>	<p>This entire section will be in if the Critical Illness</p>																																																						

<p>1. Has the Enrollee [, Spouse [or Domestic Partner]] [, or Dependent Child(ren)] ever been diagnosed with or treated for any of the following (<i>Oregon residents only</i>: during the past ten (10) years):</p> <ul style="list-style-type: none"> 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?] <p>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)?</p> <p>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?]</p>	<p>Rider is selected as a coverage option. Otherwise, this entire section will be omitted. If in:</p> <p>This will be in or out.</p>
<p>BENEFICIARY DESIGNATION</p> <p>Primary Beneficiary: Relationship: [] [<input type="checkbox"/> Spouse <input type="checkbox"/> Non-Spouse Individual <input type="checkbox"/> Trust <input type="checkbox"/> Estate <input type="checkbox"/> Charity or Other Entity]</p> <p>[SSN/Tax ID:]</p> <p>Contingent Beneficiary: Relationship: [] [<input type="checkbox"/> Spouse <input type="checkbox"/> Non-Spouse Individual <input type="checkbox"/> Trust <input type="checkbox"/> Estate <input type="checkbox"/> Charity or Other Entity]</p> <p>[SSN/Tax ID:]</p>	<p>Either the fill-in field or the check box selections will be included.</p> <p>This will be in or out.</p> <p>Either the fill-in field or the check box selections will be included.</p> <p>This will be in or out.</p>
<p>[PREMIUM INFORMATION</p> <p>Applicant: [\$0.000] [per \$[1,000] of Principal Sum] [per month]</p> <p>[plus Spouse [or Domestic Partner] Only: plus [\$0.000] [per \$[1,000] of Principal Sum] [per month]]</p> <p>[plus Dependent Child(ren) Only: plus [\$0.000] [per \$[1,000] of Principal Sum] [per month]]</p> <p>[plus Spouse [or Domestic Partner] and Dependent Child(ren): plus [\$0.000] [per \$[1,000] of Principal Sum] [per month]]</p> <p>Frequency of Payment: [<input type="checkbox"/> Annually] [<input type="checkbox"/> Semi-Annually] [<input type="checkbox"/> Quarterly] [<input type="checkbox"/> Monthly]</p>	<p>This entire section will be in or out. If in: The amount(s) due will vary by calculation and coverages selected.</p> <p>Each will be in or out.</p>

ACCIDENT [WEEKLY] INDEMNITY BENEFIT - U-IMC-117-A AR (05/11)

<p>Accident [Weekly] Indemnity Benefit</p> <p>If [You suffer] [a Covered Person suffers] a Covered Injury, which renders [You] [the Covered Person] Totally Disabled, We will pay an Accident [Weekly] Indemnity Benefit provided:</p> <p>1. the Total Disability occurs within [thirty (30)] days of the date of the Covered Injury;</p> <p>Payments will begin on the first day of Total Disability and will continue for as long as [You are] [the Covered Person is] Totally Disabled. The amount of the payments will be equal to the amount shown on the Schedule</p> <p>[reduced by [(1) Workers' Compensation Disability Benefit]; [(2) Social Security Disability Benefits excluding any amounts for which Your Dependents may qualify because of Your disability]; [(3) Social Security Retirement Benefits]; [(4) Group Disability Benefits]; [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance].</p> <p>Total Disability (Totally Disabled) means disability that...[or if for [You] [a Covered Person] who is not employed means that [You are] [the Covered Person is] unable to engage in any of the usual activities of a person of like age and sex whose health is comparable to that of [Your's] [the Covered Person's] immediately prior to the Accident...</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>[Weekly] This will be Weekly or Monthly</p> <p>[Weekly] This will be Weekly or Monthly</p> <p>The range will be 30 – 365.</p> <p>The amount shown on the Schedule will have a range from \$50 to \$10,000.</p> <p>This will be in or out. If in: Any combination of 1;2;3;4;5 may be in or out and the numbers will be adjusted accordingly.</p> <p>This will be in or out.</p> <p>[not] will be in or out.</p>
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ACCIDENTAL DISMEMBERMENT [AND COVERED LOSS OF USE] [AND PLEGIA] COVERAGE FOR DEPENDENT CHILDREN - U-IMC-119-A CW (05/11)

<p>Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children</p> <p>If a Covered Injury to [a] Dependent Child(ren) results in any of the following Covered Losses, We will pay the percentage of Principal Sum applicable to that Covered Person as shown on the Schedule. The Covered Loss must occur within [365] days of the Covered Accident.</p> <p>Percentage of the Insured's Principal Sum</p> <ol style="list-style-type: none"> [50%] to a maximum of \$[100,000] [25%] to a maximum of \$[50,000] [25%] to a maximum of \$[50,000] [12.5%] to a maximum of \$[25,000] [12.5%] to a maximum of \$[25,000] <p>[A reduced benefit will be payable equal to [fifty (50)%] of the applicable Accidental Dismemberment Coverage for dismemberment where the dismembered body part is surgically reattached, provided all other provisions of the Policy are met. The balance of the applicable Accidental Dismemberment Coverage for such dismemberment will be paid if, after [365 days], the reattachment has failed to the extent that Covered Loss of Use then exists, provided all other provisions of the Policy are met.]</p> <p>[Covered Loss of Use of</p> <ol style="list-style-type: none"> Four Limbs [50%] to a maximum of \$[100,000] Three Limbs [37.5%] to a maximum of \$[75,000] Two Limbs [33%] to a maximum of \$[66,000] One Limb [25%] to a maximum of \$[50,000] <p>[Plegia</p> <ol style="list-style-type: none"> Quadriplegia [50%] to a maximum of [100,000] [Triplegia [37.5%] to a maximum of \$[75,000]] Paraplegia [33%] to a maximum of \$[66,000] Hemiplegia [25%] to a maximum of \$[50,000] [Uniplegia (total paralysis of one Limb) [12.5%] to a maximum of \$[25,000]] <p>[Covered Loss includes [Covered Loss of Use] [and]</p>	<p>[and Covered Loss of Use] [and Plegia] will each be in or out.</p> <p>The range will be 180 - 365 days.</p> <p>The ranges will be:</p> <ol style="list-style-type: none"> 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 10%-50% \$10,000-\$250,000 10%-50% \$10,000-\$250,000 5%-25% \$ 5,000-\$125,000 This will be either in or out. If in, the range will be: 5%-25% \$ 5,000-\$125,000 <p>This will be in or out. If in: The range will be 25%-75%.</p> <p>The range will be 90-365 days.</p> <p>This will be in or out. If in: The ranges will be: 25%-75% \$25,000-\$500,000 30%-80% \$15,000-\$300,000 15%-60% \$15,000-\$300,000 10%-50% \$10,000-\$200,000</p> <p>This will be in or out. If in, The ranges will be: 1. 25%-75% \$25,000-\$500,000 2. This will be in or out. If in, the range will be: 20%-50% \$20,000-\$400,000 3. 15%-60% \$15,000-\$300,000 4. 15%-60% \$15,000-\$300,000 5. This will be in or out. If in, the range will be 10-50% \$10,000-\$200,000</p> <p>This will be in or out. If in:</p>
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<p>[Plegia].]</p> <p>[Covered Loss of Use means total paralysis of a Limb or Limbs, which [has continued for [twelve (12)] consecutive months and] is determined by Our competent medical authority to be permanent, complete and irreversible.]</p> <p>[Limb means an entire arm or a leg.]</p> <p>[Plegia must [continue for [twelve (12)] consecutive months and] be determined by Our competent medical authority to be total, permanent, complete and irreversible paralysis of [one (1)] or more Limb(s). Proof of total paralysis may be required by Us on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>[Covered Loss of Use] will be in or out; [and] will be in or out; and [Plegia] will be in or out.</p> <p>This will be either in or out. If in, The range will be 6 to 18 months.</p> <p>This will be in or out.</p> <p>This will be either in or out. If in, The range will be 6 to 18 months.</p> <p>The range will be 1 to 4 limbs.</p> <p>[not] will be in or out.</p>
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[OUT OF COUNTRY] ACCIDENT EXCESS INTEGRATED MEDIAL EXPENSE BENEFIT – U-IMC-121-A AR (05/11)

<p>[Out of Country] Accident Excess Integrated Medical Expense Benefit</p>	<p>[Out of Country] will be in or out.</p>								
<table border="0"> <tr> <td>Benefit</td> <td>Maximum Benefit</td> <td>Deductible</td> <td>Coinsurance</td> </tr> <tr> <td>Accident Medical</td> <td>[\$10,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	Benefit	Maximum Benefit	Deductible	Coinsurance	Accident Medical	[\$10,000]	[\$100]	[50%]	<p>The ranges will be as follows: [\$1,000 to \$500,000] [\$0 to \$5,000] [0% to 50%]</p>
Benefit	Maximum Benefit	Deductible	Coinsurance						
Accident Medical	[\$10,000]	[\$100]	[50%]						
<p>[Benefit Limitations:</p>	<p>The Benefit Limitations section will be in or out. If in:</p>								
<table border="0"> <tr> <td>[Accident Dental]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	[Accident Dental]	[\$1,000]	[\$100]	[50%]	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Accident Dental]	[\$1,000]	[\$100]	[50%]						
<table border="0"> <tr> <td>[Pregnancy]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	[Pregnancy]	[\$1,000]	[\$100]	[50%]	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Pregnancy]	[\$1,000]	[\$100]	[50%]						
<table border="0"> <tr> <td>[Custodial Services</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	[Custodial Services	[\$1,000]	[\$100]	[50%]	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Custodial Services	[\$1,000]	[\$100]	[50%]						
<p>We will pay the [Usual and Customary] expenses for Medically Necessary Covered Medical Service(s) [and Custodial Services] ... provided that:</p>	<p>[Usual and Customary] This will be in or out. [and Custodial Services] This will be in or out.</p>								
<ol style="list-style-type: none"> the first treatment or service occurs within [ninety (90)] days of the Covered Injury; and the medical expenses are incurred within [fifty-two (52)] weeks of the Covered Injury. 	<p>The range will be 30 to 365 days.</p>								
<p>For the purposes of this rider only, the following additional definitions apply:</p>	<p>The range will be 4 to 104 weeks.</p>								
<p>Coinsurance Percentage means the percentage of the Usual and Customary expenses for Medically Necessary Covered Medical Services [and Custodial Services] to be paid by the Covered Person after satisfaction of the deductible.</p>	<p>[and Custodial Services] this will be in or out.</p>								
<p>Covered Medical Service(s) means any of the following services:</p>	<p>The range will be 24 to 72.</p>								
<ol style="list-style-type: none"> 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. 	<p>The range will be 1 to 3 The range will be 6 to 18.</p>								
<ol style="list-style-type: none"> Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. 	<p>[excluding air ambulance]) This will be in or out.</p>								
<ol style="list-style-type: none"> Ambulance expenses for transportation from the emergency site to the Hospital [(excluding air ambulance)]. 	<p>This will be in or out.</p>								
<p>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 [You] [the Covered Person] is not a hospital confinement under this rider unless there is no charge because the Hospital is a United States government facility.</p>	<p>This will be in or out.</p>								
<p>[Medical Repatriation means transporting [You] [a</p>	<p>This will be in or out.</p>								

<p>Covered Person] back to his or principal residence or to the country where [You were] [the Covered Person was] assigned due to [You] [the Covered Person] being injured.]</p> <p>Pre-existing Condition means a condition for which [You] [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.</p> <p>[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.]</p> <p>EXCLUSIONS: Exclusions 1.; 5.; 8.; 10.; 12.; 13.; 15.; 16.; 17.; 18.; 19.; 20.;</p> <p>5. [Travel [into or within] [outside of] the United States of America.]</p> <p>11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].</p> <p>EXCESS INTEGRATED If no In Force Policy exists, [You][the Covered Person] will be required to contribute a Coinsurance Percentage of [50%], and the Policy will pay benefits after applying both the deductible and the Coinsurance Percentage.</p> <p>[SUBROGATION...]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The range will be 1 to 24.</p> <p>This will be in or out. If in:</p> <p>This will be in or out;</p> <p>This will be in or out. If in: The range will be 25% to 100%.</p> <p>Each Exclusion will be in or out.</p> <p>5. If in, [into or within] [outside of] will be in or out.</p> <p>11. [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures] will be in or out.</p> <p>The range will be 0% to 50%</p> <p>SUBROGATION. This will be in or out.</p> <p>[not] will be in or out.</p>
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[OUT OF COUNTRY] ACCIDENT EXCESS CORRIDOR MEDICAL EXPENSE BENEFIT - U-IMC-122-A AR (05/11)

<p>[Out of Country] Accident Excess Corridor Medical Expense Benefit</p>	<p>[Out of Country] will be in or out.</p>								
<table border="0"> <tr> <td>Benefit</td> <td>Maximum Benefit</td> <td>Deductible</td> <td>Coinsurance</td> </tr> <tr> <td>Accident Medical</td> <td>[\$10,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	Benefit	Maximum Benefit	Deductible	Coinsurance	Accident Medical	[\$10,000]	[\$100]	[50%]	<p>The ranges will be as follows: [\$250 to \$2,000,000] [\$0 to \$5,000] [0% to 50%]</p>
Benefit	Maximum Benefit	Deductible	Coinsurance						
Accident Medical	[\$10,000]	[\$100]	[50%]						
<p>[Benefit Limitations:</p>	<p>The Benefit Limitations section will be in or out. If in:</p>								
<table border="0"> <tr> <td>[Accident Dental]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	[Accident Dental]	[\$1,000]	[\$100]	[50%]	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Accident Dental]	[\$1,000]	[\$100]	[50%]						
<table border="0"> <tr> <td>[Pregnancy]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	[Pregnancy]	[\$1,000]	[\$100]	[50%]	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Pregnancy]	[\$1,000]	[\$100]	[50%]						
<table border="0"> <tr> <td>[Custodial Services]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50%]</td> </tr> </table>	[Custodial Services]	[\$1,000]	[\$100]	[50%]	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Custodial Services]	[\$1,000]	[\$100]	[50%]						
<p>We will pay the [Usual and Customary] expenses for Medically Necessary Covered Medical Service(s) [and Custodial Services] ... provided that:</p>	<p>[Usual and Customary] This will be in or out. [and Custodial Services] This will be in or out.</p>								
<ol style="list-style-type: none"> the first treatment or service occurs within [ninety (90)] days of the Covered Injury ; and the medical expenses are incurred within [fifty-two (52)] weeks of the Covered Injury. 	<p>The range will be 30 – 1,825 days.</p>								
<p>For the purposes of this rider only, the following additional definitions apply:</p>	<p>The range will be 4 - 520 weeks.</p>								
<p>Coinsurance Percentage means the percentage of the Usual and Customary expenses for Medically Necessary Covered Medical Services [and Custodial Services] to be paid by the Covered Person after satisfaction of the deductible.</p>	<p>[and Custodial Services] This will be in or out.</p>								
<p>Covered Medical Service(s) means...:</p>	<p>The range will be 24 - 72.</p>								
<ol style="list-style-type: none"> Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours... 	<p>The range will be 1 - 3. The range will be 6 - 18.</p>								
<ol style="list-style-type: none"> Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. 	<p>[(excluding air ambulance)] This will be in or out.</p>								
<ol style="list-style-type: none"> Ambulance expenses for transportation from the emergency site to the Hospital [(excluding air ambulance)]. 	<p>This will be in or out.</p>								
<p>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 [You] [the Covered Person] is not a hospital confinement under this rider unless there is no charge because the Hospital is a United States government facility.</p>	<p>This will be in or out.</p>								
<p>[Medical Repatriation means...]</p>	<p>This will be in or out.</p>								
<p>Pre-existing Condition means a condition for which</p>	<p>This will be in or out.</p>								

<p>[You] [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.</p> <p>[Usual and Customary Expense(s)] means...</p> <p>[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.]</p> <p>EXCLUSIONS: Exclusions 1.; 5.; 8.; 10.; 12.; 13.; 15.; 16.; 17.; 18.; 19.; 20.;</p> <p>5. [Travel [into or within] [outside of] the United States of America.] 11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].</p> <p>EXCESS CORRIDOR If no In Force Policy exists, [You][the Covered Person] will be required to contribute a Coinsurance Percentage of [50%], and the Policy will pay benefits after applying both the deductible and the Coinsurance Percentage.</p> <p>[SUBROGATION...]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>[six (6)] The range will be 1 – 24.</p> <p>This will be in or out. If in:</p> <p>This will be in or out. If in: The range will be 25% to 100%.</p> <p>Each Exclusion will be in or out.</p> <p>5. If, in, these will be in or out.</p> <p>11. [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures] will be in or out.</p> <p>The range will be 0% to 50%.</p> <p>SUBROGATION. This will be in or out.</p> <p>[not] will be in or out.</p>
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CATASTROPHE CASH BENEFIT - U-IMC-125-A AR (05/11)

The Policy Schedule will be amended to include the following:

BENEFIT	BENEFIT AMOUNT
Catastrophe	[Principal Sum]
Cash Benefit	[Maximum Amount: [\$50,000]]
	[Initial Lump Sum: [\$20,000]]
	[Monthly Amount: [\$10,000]]
	[Maximum Number of Months: [12]]

If [You suffer] [the **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss** within [365] days of the **Accident** that results in ...

The benefit is payable based on the following table:

Cause of Disability	Percentage of [Principal Sum][Maximum Amount]
Coma	[100%]
Paralysis of Two or More Limbs (Upper and/or Lower)	[100%]
Brain Death	[100%]
Paralysis of One Limb	[50%]
Paralysis of One or More Other Parts of the Body	See NOTE below

NOTE:...the percentage of the [Principal Sum][Maximum Amount]...

The benefit payable is:

[LUMP SUM: The amount shown on the Schedule.]

[MONTHLY: The benefit is payable monthly as long as [You remain] [the **Covered Person** remains] continuously **Disabled** due to the **Paralysis, Coma, or Brain Death** but ceases on the earlie[r/st] of:

1. the date [You die] [the **Covered Person** dies]; [or]
2. the date [You are] [the **Covered Person** is] no longer **Disabled** due to the **Paralysis, Coma, or Brain Death**; or
3. the date monthly benefits have been paid for the Maximum Number of Months shown in the Schedule for all **Disabilities** caused by the same **Accident**.]

[LUMP SUM THEN MONTHLY: The Initial Lump Sum amount payable; followed by a monthly benefit equal to [the percentage amount for the number of months] [pro-rated by the number of months] [amounts] stated in the Schedule. The monthly Catastrophe Cash benefit is payable...:

This will be in or out.
 This will be in or out. If in, the range will be \$5,000 - \$1,000,000.
 This will be in or out. If in, the range will be \$5,000 - \$950,000.
 This will be in or out. If in, the range will be \$1,000 - \$100,000.
 This will be in or out. If in, the range will be 3 – 60.

The range will be 90 - 365

It will be either **Principal Sum** or Maximum Amount.

The range will be 50% - 200%
 The range will be 50% - 200%

The range will be 50% - 200%
 The range will be 25% - 100%

It will be either **Principal Sum** or Maximum Amount.

This will be in or out.

This will be in or out. If in

This will be in or out.

This will be in or out. If in:
 This will be in or out.
 These will be in or out.

<p>1. the date [You die] [the Covered Person dies]; [or] 2. the date [You are] [the Covered Person is] no longer Disabled due to the Paralysis or Coma;[or] 3. the date monthly Catastrophe Cash benefits have been paid for the Maximum Number of Months shown in the Schedule for all Disabilities caused by the same Accident.]</p> <p>[If [You return] [the Covered Person returns] to...Disability.]</p> <p>Brain Death means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain for [six (6)] consecutive months, even though the heart is still beating.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out.</p> <p>This will be in or out.</p> <p>The range will be 1 – 12 consecutive months.</p> <p>[not] will be in or out.</p>
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COMA BENEFIT - U-IMC-127-A AR (05/11)

<p>If [You suffer] [a Covered Person suffers] a Covered Injury resulting in a Covered Loss within [365] days of a Covered Accident, and such Covered Injury causes [You] [the Covered Person] to be in a Coma We will pay a Coma Benefit.</p> <p>The Coma Benefit is equal to the amount shown on the Schedule and will be paid each month [You remain] [the Covered Person remains] in a Coma.</p> <p>[The Coma Benefit will be payable per the Schedule per month for the first [eleven (11)] months [You remain] [the Covered Person remains] in a Coma. At the end of the [eleven (11)] months of payment, if [You remain] [the Covered Person remains] in a Coma, We will pay a lump sum benefit equal to the Principal Sum payable under the Accidental Death Benefit less the amount of the [eleven (11)] months of benefit already received.]</p> <p>The Coma Benefit will end...</p> <p>2. [You have] [the Covered Person has] received the full Coma Benefit for [100] months.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The range will be 90 to 730 days.</p> <p>The total Coma Benefit amount will not exceed one time the Principal Sum payable per the Schedule. The range will be 1% - 100% of the Principal Sum.</p> <p>This will be in or out. If in: The range will be 11 - 24.</p> <p>The range will be 11 - 24.</p> <p>The range will be 11 - 24.</p> <p>The range will be 1 - 100.</p> <p>[not] will be in or out.</p>
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EMERGENCY TREATMENT BENEFIT - U-IMC-129-A CW (05/11)

<p>If [You suffer] [a Covered Person suffers] a Covered Injury that results in a Covered Loss and, within [forty-eight (48)] hours of the Covered Accident, is required to receive Medically Necessary Emergency Treatment [in the emergency room of a Hospital], We will pay the amount shown on the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one Covered Accident incurred by [You] [each Covered Person]. [The maximum number of Emergency Treatment Benefits payable per calendar year to [You] [each Covered Person] regardless of the number of Covered Accidents incurred, is shown on the Schedule.]</p> <p>[Hospital means an institution which:</p> <ol style="list-style-type: none"> 1. operates pursuant to law; 2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis; 3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of Physicians; and 4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.). <p>Hospital does not mean any institution or part thereof which is used primarily as:</p> <ol style="list-style-type: none"> 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. <p>However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a Hospital if it is:</p> <ol style="list-style-type: none"> 1. part of the institution that meets the above requirements; and 2. listed in the American Hospital Association Guide as a general Hospital.] <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p> 	<p>The range will be 24 - 120.</p> <p>[in the emergency room of a Hospital] This will be in or out. The standard amount shown on the Schedule will be \$500.00 and the range will be \$100.00 - \$10,000.00. [, the largest,] This will be in or out. [The maximum number... Schedule.] This will be in or out. If in, the range will be 1 to 10.</p> <p>This will be in or out.</p> <p>[not] will be in or out.</p>
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FUNERAL EXPENSE BENEFIT - U-IMC-130-A CW (05/11)

<p>Funeral Expense Benefit</p> <p>If [You sustain] [a Covered Person sustains] a Covered Injury that results in a Covered Loss payable under the [Accidental Death] Coverage, We will pay an additional Funeral Expense Benefit amount equal to the Maximum Amount for this Benefit as shown on the Schedule].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>[Accidental Death] This is to be replaced with other coverages that include an Accidental Death Coverage. The range will be \$1,000 to \$100,000.</p> <p>[not] will be in or out.</p>
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IN-HOSPITAL INDEMNITY BENEFIT - U-IMC-132-A AR (05/11)

<p>If [You suffer] [a Covered Person suffers] a Covered Injury resulting in a Covered Loss that requires Hospital Confinement for more than [seven (7)] consecutive days, We will pay the amount shown on the Schedule for a maximum of [twelve (12)] months for any Covered Injury. To be eligible for this benefit, the initial Hospital Confinement period must begin within [ninety (90)] days of the Covered Injury.</p> <p>Successive periods of Hospital Confinement arising out of the same Covered Injury will be considered one (1) confinement only if they are separated by a period of less than [three (3)] months.</p> <p>Hospital Confinement means admission to a Hospital as an inpatient [for at least twenty-four (24) consecutive hours]...</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>[seven (7)] The range will be 1 - 30. The amount We will pay on the Schedule will have a range of \$100 to \$1,000 but the total payment amount will not exceed the Principal Sum.</p> <p>[twelve (12)] The range will be 12 - 24. [ninety (90)] The range will be 1 - 365.</p> <p>The range will be 1 - 5</p> <p>This will be in or out.</p> <p>[not] will be in or out.</p>
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PERSONAL PROPERTY BENEFIT – U-IMC-134-A CW (05/11)

<p>The Policy Schedule will be amended to include the following limits for this Benefit: [\$5,000]</p> <p>If [You suffer] [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 [You sustain] [the 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].</p> <p>[We will require valid receipts of replacement goods prior to payment of any benefits.]</p> <p>Personal Property includes but is not limited to the following items [that are originally issued by a [police] [fire] [security] department and for which [You are] [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.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The Benefit limits range will be \$500 to \$5,000.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. If in: [police][fire][security] will be in or out.</p> <p>[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.</p> <p>[not] will be in or out.</p>
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TERRORISM BENEFIT - U-IMC-136-A CW (05/11)

<p>Terrorism Benefit</p> <p>If [You suffer] [a Covered Person suffers] a Covered Injury resulting in a Covered Loss, which is payable under the [Accidental Death] Coverage, that was directly caused by an Act of Terrorism [within the United States] [outside of the United States], We will pay an additional benefit equal to the amount shown on the Schedule.</p> <p>We may cancel this Terrorism Benefit by sending You at Your most recent address in Our records, a [ten (10)] day notice of Our intent to cancel.</p> <p>[United States means the United States of America [including] [excluding] its territories, possessions, and protectorates.]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>[Accidental Death] This is to be replaced with other coverages that include an Accidental Death Coverage. This will be in or out.</p> <p>This will be in or out.</p> <p>If both [within...] and [outside...] are out, the coverage is worldwide.</p> <p>The amount We will pay will have the following ranges: \$1,000 to \$100,000 or 10% to 100% of the Principal Sum.</p> <p>[ten (10)] The range will be 10 - 180 days.</p> <p>This will be in or out. If in, [including] [excluding] will be in or out.</p> <p>[not] will be in or out.</p>
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TRAVEL ASSISTANCE COVERAGE - U-IMC-137-A CW (05/11)

This Travel Assistance Coverage will apply to **You** and **Your Spouse** [/Domestic Partner] and/or **Dependent Child(ren)**, if covered under this **Policy**, when traveling [100] mile(s) or more from [Your] [the **Covered Person's**] **Principal Residence**:

[100] The range will be 0 – 1,000.

MEDICAL EVACUATION

[in accordance with **Western Medical Standards**]
[The maximum amount **We** will pay for Medical Evacuation is equal to the amount shown on the Schedule.]

This will be in or out.
This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

MEDICAL REPATRIATION

[The maximum amount **We** will pay for Medical Repatriation is shown on the Schedule].

This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

NON-MEDICAL REPATRIATION

[The maximum amount **We** will pay for Non-Medical Repatriation is shown on the Schedule].

This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

RETURN OF REMAINS

[The maximum amount **We** will pay for Return of Remains is shown on the Schedule].

This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

VISIT TO HOSPITAL

If [You are] [a **Covered Person** is] scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip**, **We**... [The maximum amount **We** will pay for Visit to Hospital is shown on the Schedule].

[seven (7)] The range will be 2 - 30.
This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

RETURN OF CHILD

If [You are] [a **Covered Person** is] traveling with [a] **Dependent Child(ren)**, who [is][are] under [nineteen (19)] years of age or [a] **Dependent Child(ren)** who prior to age [nineteen (19)] became...
[The maximum amount **We** will pay for Return of Child is shown on the Schedule.]

[nineteen (19)] The range will be 18 - 30.
[nineteen (19)] The range will be 18 - 30.
This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

RETURN OF COMPANION

[The maximum amount **We** will pay for Return of Companion is shown on the Schedule].

This will be in or out. If in, the range will be \$5,000 to \$1,000,000.

TRAVEL ASSISTANCE COVERAGE EXCLUSIONS

All Exclusions will be in unless noted otherwise. The following will be in or out:
2.;3.; 8.

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

Covered Trip means when [You are] [a **Covered Person** is] traveling more than [100] miles...

[100] The range will be 1 - 1,000.

[**Western Medical Standards** means generally accepted medical standards comparable to those in the

This will be in or out.

United States, Canada or Western Europe.]

TRAVEL ASSISTANCE COVERAGE – OTHER PROVISIONS

[Excess Coverage

Our obligation to pay **[You]** [the **Covered Person**] under this Travel Assistance Coverage will be excess of any other insurance which **[You have]** [the **Covered Person** has] with respect to the expenses covered under this Travel Assistance Coverage.]

Reservation of Rights

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

[Exempted Countries

This Travel Assistance Coverage is not available in the following countries: [Iran]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to **You**.]

Scope

[Covered transportation expenses will be limited to air and marine conveyance.]

[To contact **Us** regarding this Travel Assistance Coverage, **[You]** [the **Covered Person**] must call [1-800-263-0261] from the U.S. or Canada; and collect from anywhere else in the world at [+1-416-977-0277].

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

This will be in or out.

This will be in or out.

This will be in or out. If in:

[Iran] This list could include multiple countries. [ten (10)] The range will be 10 - 90.

This will be in or out.

This will be in or out. The telephone numbers would be updated as necessary.

[not] will be in or out.

[OUT OF COUNTRY] ACCIDENT MEDICAL EXPENSE BENEFIT – U-IMC-138-A AR (05/11)

<p>[Out of Country] Accident Medical Expense Benefit</p>	<p>[Out of Country] will be in or out.</p>								
<table border="0"> <tr> <td>Benefit</td> <td>Maximum Benefit</td> <td>Deductible</td> <td>Coinsurance</td> </tr> <tr> <td>Accident Medical</td> <td>[\$10,000]</td> <td>[\$100]</td> <td>[50]%</td> </tr> </table>	Benefit	Maximum Benefit	Deductible	Coinsurance	Accident Medical	[\$10,000]	[\$100]	[50]%	<p>The ranges will be as follows: [\$1,000 to \$500,000] [\$0 to \$5,000] [0% to 50%]</p>
Benefit	Maximum Benefit	Deductible	Coinsurance						
Accident Medical	[\$10,000]	[\$100]	[50]%						
<p>[Benefit Limitations:</p>	<p>The Benefit Limitations section will be in or out. If in:</p>								
<table border="0"> <tr> <td>[Accident Dental]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50]%</td> </tr> </table>	[Accident Dental]	[\$1,000]	[\$100]	[50]%	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Accident Dental]	[\$1,000]	[\$100]	[50]%						
<table border="0"> <tr> <td>[Pregnancy]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50]%</td> </tr> </table>	[Pregnancy]	[\$1,000]	[\$100]	[50]%	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Pregnancy]	[\$1,000]	[\$100]	[50]%						
<table border="0"> <tr> <td>[Custodial Services]</td> <td>[\$1,000]</td> <td>[\$100]</td> <td>[50]%</td> </tr> </table>	[Custodial Services]	[\$1,000]	[\$100]	[50]%	<p>This will be in or out. If in, the ranges will be: [\$100 to \$10,000] [\$0 to \$5,000] [0% to 50%]</p>				
[Custodial Services]	[\$1,000]	[\$100]	[50]%						
<p>We will pay the [Usual and Customary] expenses for Medically Necessary Covered Medical Service(s) [and Custodial Services] . . . provided that:</p>	<p>[Usual and Customary] This will be in or out. [and Custodial Services] This will be in or out.</p>								
<ol style="list-style-type: none"> the first treatment or service occurs within [ninety (90)] days of the Covered Injury; and the medical expenses are incurred within [fifty-two (52)] weeks of the Covered Injury. 	<p>The range will be 30 - 365 days. The range will be 4 - 104 weeks.</p>								
<p>For the purposes of this rider only, the following additional definitions apply:</p>									
<p>Coinsurance Percentage means the percentage of the Usual and Customary expenses for Medically Necessary Covered Medical Services [and Custodial Services] to be paid by the Covered Person after satisfaction of the deductible.</p>	<p>[and Custodial Services] this will be in or out.</p>								
<p>Covered Medical Service(s) means any of the following services:</p>									
<ol style="list-style-type: none"> 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. 	<p>The range will be 24 - 72</p>								
<ol style="list-style-type: none"> Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve (12)] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, message or any form of physical therapy. 	<p>The range will be 1 - 3 The range will be 6 - 18</p>								
<ol style="list-style-type: none"> Ambulance expenses for transportation from the emergency site to the Hospital [(excluding air ambulance)]. 	<p>[(excluding air ambulance)] This will be in or out.</p>								
<p>[Medical Repatriation means transporting [You] [a Covered Person] back to [Your] [the Covered Person's] principal residence or to the country where [You were] [the</p>	<p>This will be in or out.</p>								

<p>Covered Person was] assigned due to [You] [the Covered Person] being injured.]</p> <p>Pre-existing Condition means a condition for which [You] [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.</p> <p>[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.]</p> <p>EXCLUSIONS: Exclusions 1.; 5.; 8.; 10.; 12.; 13.; 15.; 16.; 17.; 18.; 19.; 20.</p> <p>5. [Travel [into or within] [outside of] the United States of America.]</p> <p>11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].</p> <p>[SUBROGATION] We have the right to recover from any third party...]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The range will be 1 - 24</p> <p>This will be in or out. If in:</p> <p>This will be in or out.</p> <p>This will be in or out. If in: The range will be 25% to 100%.</p> <p>Each Exclusion will be in or out.</p> <p>5. If in, [into or within] [outside of] will be in or out.</p> <p>11. [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures] will be in or out.</p> <p>SUBROGATION. This will be in or out.</p> <p>[not] will be in or out.</p>
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CRITICAL ILLNESS COVERAGE - U-IMC-140-A AR (05/11)

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 [You reach] [the **Covered Person** reaches] age [sixty-five (65)].
- b. If the **Policy's Principal Sum** is decreased for any other reason, such that the **Coverage Amount** exceeds [fifty percent (50%)] of the **Principal Sum**, such **Coverage Amount** will be reduced to [fifty percent (50%)] of the remaining **Principal Sum**.

[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 [You] [the **Covered Person**] exceeds [\$250,000.00], the **Coverage Amount** for each such Coverage and Policy will be decreased proportionately such that the sum of the **Coverage Amounts** becomes [\$250,000.00] before any claim is paid. **We** will adjust the premiums for such Coverages and policies and refund to [You] the excess of premiums already paid over the premiums that should have been paid for the new **Coverage Amount**, without interest.]

[**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 [thirty (30)] day **Waiting Period**. Clinical Diagnosis of Cancer shall be accepted as evidence that cancer exists when a pathological diagnosis is medically inappropriate.

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

The range will be 5% to 100% of the **Coverage Amount**.

The range will be from age 50 to 85.

The range will be 5% to 100%.

The range will be 5% to 100%.

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.

This will be in or out. If in:

The range will be 10 to 30 days.

<p>3 or greater.</p> <p>g. Papillary microinvasive Cancer of the thyroid, bladder, cervix, or breast.]</p> <p>[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 [thirty (30)] day Waiting Period. The Diagnosis must be supported by all of the following:</p> <ol style="list-style-type: none"> A history consistent with Heart Attack; 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; Elevation of cardiac enzymes, including CPK-MB and troponin; and If performed, nuclear imaging scan or echocardiogram consistent with Myocardial Infarction. <p>[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.]]</p> <p>[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 [thirty (30)] day Waiting Period.]</p> <p>[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 [thirty (30)] day Waiting Period.] [Excluded from coverage is Loss of Limb(s) due to a disease process.]]</p> <p>[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 qualified Physician and must first occur after a [thirty (30)] day Waiting Period.]</p> <p>[Paralysis means the loss of motor function due to neurological injury. The Paralysis must have been present for a continuous period of at least [ninety (90)] days. To qualify for the Coverage Amount, the Loss of Limb(s)</p>	<p>This will be in or out. If in:</p> <p>The range will be 10 to 30 days.</p> <p>This will be in or out.</p> <p>This will be in or out. If in:</p> <p>The range will be 5 to 30 days.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 30 days.</p> <p>This will be in or out.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 30 days.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 180 days.</p>
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<p>must first occur after a [thirty (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).]</p> <p>[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 [thirty (30)] day Waiting Period. The Stroke must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [thirty (30)] days and be verified by computed tomography (CT) scan or magnetic resonance imaging (MRI). [Excluded from coverage are:</p> <ol style="list-style-type: none"> 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.]] <p>5. [Preexisting Condition means a condition for which symptoms existed within [two (2) years] prior to the later of the Coverage Effective Date or the effective date of any Coverage reinstatement. If [You are] [the 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 for 12 months following the effective date of this Rider.]</p> <p>7. Payment of the Coverage Amount is subject to all of the following conditions:</p> <ol style="list-style-type: none"> 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 [You] [the Covered Person] may not exceed [\$250,000.00]. <p>8. Exclusions and Limitations [a; b; c, i, ii, iii]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The range will be 10 to 30 days. This will be in or out.</p> <p>This will be in or out. If in:</p> <p>The range will be 10 to 30 days.</p> <p>The range will be 10 to 180 days.</p> <p>This will be in or out.</p> <p>This will be in or out. The range will be 6 months - 5 years.</p> <p>The range will be \$1,000 to \$1,000,000.</p> <p>Exclusions: These will be in or out.</p> <p>[not] will be in or out.</p>
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WELLNESS BENEFIT - U-IMC-143-A CW (05/11)

<p>The Policy Schedule will be amended to include the following limits for this Benefit: [\$50]</p> <p>If after this Policy has been in force for [six (6)] months, [You undergo] [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.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The range will be \$50 - \$1,000</p> <p>The range will be 1 - 6 months.</p> <p>[not] will be in or out.</p>
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WAIVER OF PREMIUM DUE TO UNEMPLOYMENT - U-IMC-144-A CW (05/11)

<p>The Policy Schedule will be amended to include the following Benefit.</p> <p>If You become Unemployed while covered under this Policy, We will waive the premium due from You under this Policy, provided the Unemployment continues for a period greater than [180] consecutive days.</p> <p>Premium payments must continue for the first [180] days of the continuous Unemployment. After the initial [180] day period of continuous Unemployment, Your premium for this Policy will be waived until the earliest of the following:</p> <ol style="list-style-type: none">1. You are no longer Unemployed.2. the Policy terminates.3. [sixty (60)] days has expired since the Waiver of Premium was granted by Us.4. [You attain age [70].] <p>For purposes of this rider only, Unemployed/Unemployment means that You were a full time employee within [180] days prior to the request for Waiver of Premium and was involuntarily discharged from that employment and are registered with the appropriate government employment agency.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The range will be 90 to 180 days.</p> <p>The range will be 90 to 180 days.</p> <p>The range will be 90 to 180 days.</p> <p>The range will be 30 to 180 days.</p> <p>This will be in or out. If in, the range will be age 50 to 85.</p> <p>The range will be 90 to 180 days.</p> <p>[not] will be in or out.</p>
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NO CLAIM DISCOUNT – U-IMC-145-A CW (05/11)

<p>The Policy Schedule will be amended to include the following Benefit.</p> <p>If after the Policy has been in force for [three (3)] years, and no claim has been filed or paid under the coverages for this Policy, [except for Wellness Benefits,] You are entitled to a No Claim Discount.</p> <p>For the purpose of this rider only, a No Claim Discount means a one-time premium reduction of [ten percent (10%)] off the annual premium as stated in the Schedule of the Policy. 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.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The limit amount on the Schedule will have a range of 1% to 10%.</p> <p>The range will be 1 to 5 years.</p> <p>This will be in or out.</p> <p>The range will be 1% to 10%.</p> <p>[not] will be in or out.</p>
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ACCIDENTAL DISMEMBERMENT [AND LOSS OF] [AND PLEGIA] COVERAGE - U-IMC-146-A CW (05/11)

<p>Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage</p> <p>If a Covered Injury to [You] [a Covered Person] [or] [Your covered Spouse/Domestic Partner] results in any of the following Covered Losses, We will pay the percentage of the Principal Sum applicable to that Covered Person as shown on the Schedule. The Covered Loss must occur within [365] days of the Covered Accident.</p> <ol style="list-style-type: none"> 1. [100% of Principal Sum] 2. [100% of Principal Sum] 3. [100% of Principal Sum] 4. [100% of Principal Sum] 5. [100% of Principal Sum] 6. [50% of Principal Sum] 7. [50% of Principal Sum] 8. [25% of Principal Sum] 9. [25% of Principal Sum] <p>[A reduced benefit will be payable equal to [fifty percent (50%)] of the applicable Accidental Dismemberment Benefit after [365 days],</p> <p>[Covered Loss of Use of</p> <ol style="list-style-type: none"> 1. Four Limbs [100% of Principal Sum] 2. Three Limbs [75% of Principal Sum] 3. Two Limbs [66 2/3% of Principal Sum] 4. One Limb [50% of Principal Sum] <p>[Plegia</p> <ol style="list-style-type: none"> 1. Quadriplegia [100% of Principal Sum] 2. [Triplegia [75% of Principal Sum]] 3. [Paraplegia [66 2/3% of Principal Sum]] 4. [Hemiplegia [50% of Principal Sum]] 5. [Uniplegia] [25% of Principal Sum]] <p>[Covered Loss includes [Covered Loss of Use] [and] [Plegia].]</p> <p>[Covered Loss of Use means total paralysis of a Limb or Limbs, which [has continued for [twelve (12)] consecutive months and] is determined by Our competent medical authority to be permanent, complete and irreversible.]</p> <p>[Plegia must [continue for [twelve (12)] consecutive months and] be determined by Our competent medical authority to be total, permanent, complete and irreversible paralysis of [one (1)] or more Limb(s).]</p>	<p>[and Covered Loss of Use] [and Plegia] will each be in or out.</p> <p>[Your covered Spouse/Domestic Partner] will be either in or out.</p> <p>The range will be 180-365 days</p> <ol style="list-style-type: none"> 1. The range will be 50%-200% 2. The range will be 50%-200% 3. The range will be 50%-200% 4. The range will be 50%-200% 5. The range will be 50%-200% 6. The range will be 25%-100% 7. The range will be 25%-100% 8. The range will be 12.5%-50% 9. This will be in or out. If in, the range will be 25%-50% <p>This will be either in or out. If in: The range will be 25%-75% The range will be 90-365 days</p> <p>This will be either in or out. If in, The range will be 50%-200% The range will be 37.5%-150% The range will be 33 1/3%–125% The range will be 25%-100%</p> <p>This will be either in or out. If in, 1. The range will be 50%-200%. This will be either in or out. If in: 2. The range will be 37.5%-150%. 3. The range will be 33 1/3%-75%. 4. The range will be 25%-100% 5. The range will be 12.5%-100%</p> <p>This will be in or out. If in: [Covered Loss of Use] will be in or out; [and] will be in or out; and [Plegia] will be in or out.</p> <p>This will be either in or out. This will be either in or out. If in: The range will be 6 - 18.</p> <p>This will be either in or out. If in: The range will be 6 - 18.</p> <p>The range will be 1 - 4 limbs.</p>
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[Limb means an entire arm or a leg.]

This will be either in or out.

This rider is [not] subject to the limitations in Section V
General Limitations of the **Policy**

[not] will be in or out.

In-Hospital Indemnity Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss** that requires **Hospital Confinement** for more than [seven (7)] consecutive days, **We** will pay the amount shown on the Schedule for a maximum of [twelve (12)] months for any **Covered Injury**. To be eligible for this benefit, the initial **Hospital Confinement** period must begin within [ninety (90)] days of the **Covered Injury**.

Successive periods of **Hospital Confinement** arising out of the same **Covered Injury** will be considered one (1) confinement only if they are separated by a period of less than [three (3)] months.

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

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 or rehabilitation facilities;
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 Confinement means admission to a **Hospital** as an inpatient [for at least twenty-four (24) consecutive hours] by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to [You] [the **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 rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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



ZURICH

[Out of Country] Accident Medical Expense Benefit

Zurich American Insurance Company

1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

Accident Medical Expense Schedule			
Benefit	Maximum Benefit [per Covered Person] per Covered Accident	Deductible [per Covered Person] per Covered Accident	Coinsurance Percentage [per Covered Person] per Covered Accident
Accident Medical	[\$10,000]	[\$100]	[50]%
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[50]%
[Pregnancy]	[\$1,000]	[\$100]	[50]%
[Custodial Services]	[\$1,000]	[\$100]	[50]%

We will pay the [Usual and Customary] expenses for **Medically Necessary Covered Medical Service(s)** [and **Custodial Services**] incurred by [You] [the **Covered Person**] resulting from a **Covered Accident**, up to the Maximum Benefit shown on the Accident Medical Expense 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 additional definitions apply:

Coinsurance Percentage means the percentage of the **Usual and Customary** expenses for **Medically Necessary Covered Medical Services** [and **Custodial Services**] to be paid by the **Covered Person** after satisfaction of the deductible.

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

1. **Hospital** room and board expenses: the daily room rate when [You are] [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.
9. The services of a registered nurse not **Related** to [You] [the **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, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless 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 [You] [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 [You] [the **Covered Person**];
2. related to performing, or assisting [You] [the **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 [You] [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, or rehabilitation facilities;
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 [You] [the **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 [You] [a **Covered Person**] back to [Your] [the **Covered Person's**] principal residence or to the country where [You were] [the **Covered Person** was] assigned due to [You] [the **Covered Person**] being injured.]

Pre-existing Condition means a condition for which [You] [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**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

[Usual and Customary 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 Section IV of 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** until 12 months after the effective date of this Rider.
4. **Covered Injury** for which [You are] [the **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 [You] [the **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 [**You** are] [the **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. [**You**] [A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in [**Your**] [the **Covered Person's**] 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 [**Your**] [the **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 [**You**] [the **Covered Person**] or on behalf of **Your Spouse or Domestic Partner, Dependent Child(ren)**, heirs, guardians or executors or will be obligated to pay in the future to **You**. If [**You** recover] [the **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 [**You**] [the **Covered Person**]. [**You** agree] [the **Covered Person** agrees] to assist **Us** in preserving **Our** rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Critical Illness Coverage



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

CAUTION: This is a limited policy. Read it carefully with the outline of coverage

This Coverage modifies insurance provided under the Individual Accident Policy.

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

1. Coverage - Under the terms of the Critical Illness Coverage, **We** will pay [**You**] [the **Covered Person**] the **Coverage Amount** as a coverage payment:
 - a. If [**You are**] [the **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**, unless the loss is due to a pre-existing condition for a period greater than 12 months following the effective date of this Rider;
 - 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 [**You die**] [the **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 [fifty percent (50%)] of the **Coverage Amount** when [**You reach**] [the **Covered Person reaches**] age [sixty-five (65)].
 - b. If the **Policy's Principal Sum** is decreased for any other reason, such that the **Coverage Amount** exceeds [fifty percent (50%)] of the **Principal Sum**, such **Coverage Amount** will be reduced to [fifty percent (50%)] 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 [**You**] [the **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 [\$250,000.00] before any claim is paid. **We** will adjust the premiums for such Coverages and policies and refund to [**You**] 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 [thirty (30)] day **Waiting Period**. Clinical Diagnosis of Cancer shall be accepted as evidence that cancer exists when a pathological diagnosis is medically inappropriate.

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 [thirty (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 [thirty (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 [thirty (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 qualified **Physician** and must first occur after a [thirty (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 [ninety (90)] days. To qualify for the **Coverage Amount**, the **Paralysis** must first occur after a [thirty (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 [thirty (30)] day **Waiting Period**. The **Stroke** must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [thirty (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**. [You] [the **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 [Your] [the **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 **You** 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 **[Your]** **[the 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 (2) years] prior to the later of the Coverage Effective Date or the effective date of any Coverage reinstatement. If **[You are]** **[the 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** for 12 months following the effective date of this Rider.]
 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 **[You]** **[the Covered Person]** may not exceed [\$250,000.00].
 - b. Only one **Coverage Amount** payment is allowed during **[Your]** **[the Covered Person's]** lifetime, 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 **[You]** **[the Covered Person]** and **Your Spouse**, other beneficiaries, and any other person, if in **Our** 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 **[You are]** **[the 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, **[You refuse]** **[the Covered Person refuses]** this treatment, and **[You suffer]** **[the Covered Person suffers]** a **Heart Attack**;
 - ii. [A **Physician** has recommended treatment for a brain aneurysm or carotid artery stenosis, **[You refuse]** **[the Covered Person refuses]** treatment, and **[You suffer]** **[the 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**, **[You refuse]** **[the Covered Person refuses]**, and **[You develop]** **[the Covered Person develops]** **Cancer**.]
- If **[You are]** **[the 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** for 12 months following the effective date of this Rider. 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. **[Your]** **[the 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 **[You]** [the **Covered Person**], any irrevocable beneficiary, and any permitted assignees, showing the effect of the **Coverage Amount** payment on the **Policy** when **[You receive]** [the **Covered Person** receives] payment of the **Coverage Amount**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

SERFF Tracking Number: ZURC-127626045 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 49957
 Company Tracking Number: CW AH 33365
 TOI: H03I Individual Health - Accidental Death & Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment
 Dismemberment
 Product Name: Additional Riders for Accident Insurance Policy
 Project Name/Number: Additional Riders for Accident Insurance Policy/CW AH 33365

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/14/2011	Form	In-Hospital Indemnity Benefit	11/16/2011	U-IMC-132-A AR - In-Hospital Indemnity Benefit.pdf (Superseded)
09/14/2011	Form	[Out of Country] Accident Medical Expense Benefit	11/16/2011	U-IMC-138-A AR - AME Primary.pdf (Superseded)
09/14/2011	Form	Critical Illness Coverage	11/17/2011	U-IMC-140-A AR - Critical Illness Coverage.pdf (Superseded)

In-Hospital Indemnity Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

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

If [You suffer] [a **Covered Person** suffers] a **Covered Injury** resulting in a **Covered Loss** that requires **Hospital Confinement** for more than [seven (7)] consecutive days, **We** will pay the amount shown on the Schedule for a maximum of [twelve (12)] months for any **Covered Injury**. To be eligible for this benefit, the initial **Hospital Confinement** period must begin within [ninety (90)] days of the **Covered Injury**.

Successive periods of **Hospital Confinement** arising out of the same **Covered Injury** will be considered one (1) confinement only if they are separated by a period of less than [three (3)] months.

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

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 Confinement means admission to a **Hospital** as an inpatient [for at least twenty-four (24) consecutive hours] by a **Physician** for a **Covered Injury**. A **Hospital** stay that does not result in charges to [You] [the **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 rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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



ZURICH

[Out of Country] Accident Medical Expense Benefit

Zurich American Insurance Company

1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This rider modifies insurance provided under the Individual Accident Policy.

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

Accident Medical Expense Schedule			
Benefit	Maximum Benefit [per Covered Person] per Covered Accident	Deductible [per Covered Person] per Covered Accident	Coinsurance Percentage [per Covered Person] per Covered Accident
Accident Medical	[\$10,000]	[\$100]	[50]%
[Benefit Limitations:			
[Accident Dental]	[\$1,000]	[\$100]	[50]%
[Pregnancy]	[\$1,000]	[\$100]	[50]%
[Custodial Services]	[\$1,000]	[\$100]	[50]%

We will pay the [Usual and Customary] expenses for **Medically Necessary Covered Medical Service(s)** [and **Custodial Services**] incurred by [You] [the **Covered Person**] resulting from a **Covered Accident**, up to the Maximum Benefit shown on the Accident Medical Expense 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 additional definitions apply:

Coinsurance Percentage means the percentage of the **Usual and Customary** expenses for **Medically Necessary Covered Medical Services** [and **Custodial Services**] to be paid by the **Covered Person** after satisfaction of the deductible.

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

1. **Hospital** room and board expenses: the daily room rate when [You are] [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.
9. The services of a registered nurse not **Related** to [You] [the **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, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless 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 [You] [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 [You] [the **Covered Person**];
2. related to performing, or assisting [You] [the **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 [You] [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 [You] [the **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 [You] [a **Covered Person**] back to [Your] [the **Covered Person's**] principal residence or to the country where [You were] [the **Covered Person** was] assigned due to [You] [the **Covered Person**] being injured.]

Pre-existing Condition means a condition for which [You] [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**.

Sound Natural Teeth means natural teeth that are unaltered or are fully restored to their normal function and are disease free, have no decay, and are not more susceptible to injury than unaltered natural teeth.

[Usual and Customary 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 Section IV of 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** until 12 months after the effective date of this Rider.
4. **Covered Injury** for which [You are] [the **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 [You] [the **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 [**You** are] [the **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. [**You**] [A **Covered Person**] will be conclusively presumed to be legally intoxicated if the level of alcohol in [**Your**] [the **Covered Person's**] 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 [**Your**] [the **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 [**You**] [the **Covered Person**] or on behalf of **Your Spouse or Domestic Partner, Dependent Child(ren)**, heirs, guardians or executors or will be obligated to pay in the future to **You**. If [**You** recover] [the **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 [**You**] [the **Covered Person**]. [**You** agree] [the **Covered Person** agrees] to assist **Us** in preserving **Our** rights against any third party, including but not limited to, signing subrogation forms supplied by **Us**.]

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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

Critical Illness Coverage



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

THIS RIDER CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This policy IS NOT A MEDICARE SUPPLEMENT POLICY.

CAUTION: This is a limited policy. Read it carefully with the outline of coverage

This Coverage modifies insurance provided under the Individual Accident Policy.

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

1. Coverage - Under the terms of the Critical Illness Coverage, **We** will pay [**You**] [the **Covered Person**] the **Coverage Amount** as a coverage payment:
 - a. If [**You are**] [the **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**, unless the loss is due to a pre-existing condition for a period greater than 12 months following the effective date of this Rider;
 - 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 [**You die**] [the **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 [fifty percent (50%)] of the **Coverage Amount** when [**You reach**] [the **Covered Person reaches**] age [sixty-five (65)].
 - b. If the **Policy's Principal Sum** is decreased for any other reason, such that the **Coverage Amount** exceeds [fifty percent (50%)] of the **Principal Sum**, such **Coverage Amount** will be reduced to [fifty percent (50%)] 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 [**You**] [the **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 [\$250,000.00] before any claim is paid. **We** will adjust the premiums for such Coverages and policies and refund to [**You**] 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 [thirty (30)] day **Waiting Period**. Clinical Diagnosis of Cancer shall be accepted as evidence that cancer exists when a pathological diagnosis is medically inappropriate.

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 [thirty (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 [thirty (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 [thirty (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 qualified **Physician** and must first occur after a [thirty (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 [ninety (90)] days. To qualify for the **Coverage Amount**, the **Paralysis** must first occur after a [thirty (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 [thirty (30)] day **Waiting Period**. The **Stroke** must produce a symptomatic and measurable neurological deficit persisting for a continuous period of at least [thirty (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**. [You] [the **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 [Your] [the **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 **You** 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 **[Your]** **[the 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 (2) years] prior to the later of the Coverage Effective Date or the effective date of any Coverage reinstatement. If **[You are]** **[the 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** for 12 months following the effective date of this Rider.]
 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 **[You]** **[the Covered Person]** may not exceed [\$250,000.00].
 - b. Only one **Coverage Amount** payment is allowed during **[Your]** **[the Covered Person's]** lifetime, 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 **[You]** **[the Covered Person]** and **Your Spouse**, other beneficiaries, and any other person, if in **Our** 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 **[You are]** **[the 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, **[You refuse]** **[the Covered Person refuses]** this treatment, and **[You suffer]** **[the Covered Person suffers]** a **Heart Attack**;
 - ii. [A **Physician** has recommended treatment for a brain aneurysm or carotid artery stenosis, **[You refuse]** **[the Covered Person refuses]** treatment, and **[You suffer]** **[the 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**, **[You refuse]** **[the Covered Person refuses]**, and **[You develop]** **[the Covered Person develops]** **Cancer**.]]
- If **[You are]** **[the 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** for 12 months following the effective date of this Rider. 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. **[Your]** **[the 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 **[You]** [the **Covered Person**], any irrevocable beneficiary, and any permitted assignees, showing the effect of the **Coverage Amount** payment on the **Policy** when **[You receive]** [the **Covered Person** receives] payment of the **Coverage Amount**.

This rider is [not] subject to the limitations in Section V General Limitations of the **Policy**.

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

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