

SERFF Tracking Number: ZURC-127848523 State: Arkansas
Filing Company: Zurich American Insurance Company State Tracking Number: 50350
Company Tracking Number: CW AH 33801
TOI: H03G Group Health - Accidental Death & Dismemberment Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment
Product Name: Group Accident Policy - Additional Optional Riders
Project Name/Number: CW AH 33801 - Group Accident Policy - Additional Optional Riders/CW AH 33801

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Group Accident Policy - Additional Optional Riders SERFF Tr Num: ZURC-127848523 State: Arkansas

TOI: H03G Group Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved State Tr Num: 50350

Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment Co Tr Num: CW AH 33801 State Status: Approved-Closed

Filing Type: Form

Author: Karen Falbo

Date Submitted: 11/28/2011

Reviewer(s): Donna Lambert

Disposition Date: 12/05/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 01/05/2012

State Filing Description:

General Information

Project Name: CW AH 33801 - Group Accident Policy - Additional Optional Riders

Status of Filing in Domicile: Pending

Project Number: CW AH 33801

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Association, Other

Explanation for Other Group Market Type: Financial Institutions, Creditors, Credit Unions, Trustees and Vendors, etc.

Overall Rate Impact:

Filing Status Changed: 12/05/2011

State Status Changed: 12/05/2011

Deemer Date:

Created By: Karen Falbo

Submitted By: Karen Falbo

Corresponding Filing Tracking Number:

Filing Description:

Attached for your review are twenty (20) new riders for use with the Group Accident Insurance product, previously filed with and authorized by your Department under Company Tracking Number CW AH 29266 and State Tracking Number: 44163.

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As previously indicated, the Group Accident Insurance product and these new riders will be marketed to all statutorily eligible groups in your state consisting of two (2) or more individuals. Eligible groups shall include, but are not limited to: credit union groups; debtor groups; creditor groups; vendor groups; association groups; and financial institutions.

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

With the exception of our Administrative Change Endorsement, form U-GMC-104-B CW (09/11), these riders are new and are not intended to replace any other forms currently in use.

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

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

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
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$1,000.00	11/28/2011	54084558

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/05/2011	12/05/2011

SERFF Tracking Number: ZURC-127848523 *State:* Arkansas
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Disposition

Disposition Date: 12/05/2011

Implementation Date: 01/05/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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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	Explanatory	Approved	Yes
Supporting Document	Statement of Variables	Approved	Yes
Supporting Document	Marked U-GMC-104 to show revisions	Approved	Yes
Form	Administrative Change Endorsement	Approved	Yes
Form	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	Approved	Yes
Form	After School Care Benefit	Approved	Yes
Form	Inflation Benefit	Approved	Yes
Form	HIV Occupational Accident Benefit	Approved	Yes
Form	[Permanent] [Temporary] Total Disability Benefit	Approved	Yes
Form	Critical Burn Benefit	Approved	Yes
Form	Continuation of Insurance Benefit	Approved	Yes
Form	Day Care Benefit	Approved	Yes
Form	Hearing Aid or Prosthetic Appliance Benefit	Approved	Yes
Form	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	Approved	Yes
Form	Traumatic Brain Injury Benefit	Approved	Yes
Form	Home Alteration and Vehicle Modification Benefit	Approved	Yes
Form	Natural Disaster Benefit	Approved	Yes
Form	[Occupational] [or] [Volunteer Activity] Hepatitis Benefit	Approved	Yes
Form	Recuperation Benefit	Approved	Yes
Form	Student [Tuition] [and] [Expense] Reimbursement Benefit	Approved	Yes
Form	Accelerated Payment Benefit	Approved	Yes
Form	Accident Medical Expense - Indemnity Benefit	Approved	Yes
Form	Complications of Pregnancy Benefit	Approved	Yes

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Form Schedule

Lead Form Number: U-GMC-100-A

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/05/2011	U-GMC-104-B CW (09/11)	Policy/Contract	Administrative Change Endorsement Certificate: Amendment, Insert Page, Endorsement or Rider	Revised	Replaced Form #: U-GMC-104-A CW (08/09) Previous Filing #: 44163	0.000	U-GMC-104-B CW - Administrative Change Endorsement CLN 10-03-11.pdf
Approved 12/05/2011	U-GMC-109-A CW (09/11)	Policy/Contract	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	U-GMC-109-A CW - Additional Dismemberment for Children Benefit.pdf
Approved 12/05/2011	U-GMC-123-A CW (09/11)	Policy/Contract	After School Care Benefit Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	U-GMC-123-A CW - After School Care Benefit.pdf
Approved 12/05/2011	U-GMC-124-A CW (09/11)	Policy/Contract	Inflation Benefit Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	U-GMC-124-A CW - Inflation

<i>SERFF Tracking Number:</i>	<i>ZURC-127848523</i>	<i>State:</i>	<i>Arkansas</i>		
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>50350</i>		
<i>Company Tracking Number:</i>	<i>CW AH 33801</i>				
<i>TOI:</i>	<i>H03G Group Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death & Dismemberment</i>		
<i>Product Name:</i>	<i>Group Accident Policy - Additional Optional Riders</i>				
<i>Project Name/Number:</i>	<i>CW AH 33801 - Group Accident Policy - Additional Optional Riders/CW AH 33801</i>				
		Certificate:	Benefit.pdf		
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-GMC-	Policy/Cont HIV Occupational	Initial	0.000	U-GMC-131-
12/05/2011	131-A CW	ract/Fratern Accident Benefit			A CW - HIV
	(09/11)	al			Occ Acc
		Certificate:			Benefit.pdf
		Amendmen			
		t, Insert			
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		Endorseme			
		nt or Rider			
Approved	U-GMC-	Policy/Cont [Permanent]	Initial	0.000	U-GMC-139-
12/05/2011	139-A CW	ract/Fratern [Temporary] Total			A CW -
	(09/11)	al Disability Benefit			Permanant
		Certificate:			Temporary
		Amendmen			Total
		t, Insert			Disability.pdf
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-GMC-	Policy/Cont Critical Burn Benefit	Initial	0.000	U-GMC-141-
12/05/2011	141-A CW	ract/Fratern			A CW -
	(09/11)	al			Critical Burn
		Certificate:			Benefit.pdf
		Amendmen			
		t, Insert			
		Page,			
		Endorseme			
		nt or Rider			
Approved	U-GMC-	Policy/Cont Continuation of	Initial	0.000	U-GMC-147-
12/05/2011	147-A CW	ract/Fratern Insurance Benefit			A CW -
	(09/11)	al			Continuation
		Certificate:			of Ins

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		t, Insert Page, Endorseme nt or Rider			
Approved 12/05/2011	U-GMC- 171-A CW (09/11)	Policy/Cont Home Alteration and Initial ract/Fratern Vehicle Modification al Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	U-GMC-171- A CW - Home Alteration and Vehicle Moderation Benefit.pdf
Approved 12/05/2011	U-GMC- 172-A CW (09/11)	Policy/Cont Natural Disaster ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	U-GMC-172- A CW - Natural Disaster Benefit.pdf
Approved 12/05/2011	U-GMC- 173-A CW (09/11)	Policy/Cont [Occupational] [or] ract/Fratern [Volunteer Activity] al Hepatitis Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	U-GMC-173- A CW - Occupational or Volunteer Hepatitis Benefit.pdf
Approved 12/05/2011	U-GMC- 174-A CW (09/11)	Policy/Cont Recuperation Benefit ract/Fratern al Certificate: Amendmen t, Insert	Initial	0.000	U-GMC-174- A CW - Recuperation Benefit.pdf

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Approval Date	Policy/Contract	Description	Initial	Amount	Attachment
Approved 12/05/2011	U-GMC-175-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Student [Tuition] [Expense] Reimbursement	0.000	U-GMC-175-A CW - Tuition Reimbursement.pdf
Approved 12/05/2011	U-GMC-176-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accelerated Payment Benefit	0.000	U-GMC-176-A CW - Accelerated Payment Benefit.pdf
Approved 12/05/2011	U-GMC-177-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accident Medical Expense - Indemnity Benefit	0.000	U-GMC-177-A CW - AME Indemnity.pdf
Approved 12/05/2011	U-GMC-178-A CW (09/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page,	Complications of Pregnancy Benefit	0.000	U-GMC-178-A CW - Complications of Pregnancy.pdf

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Dismemberment Dismemberment
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**Endorseme
nt or Rider**

Administrative Change Endorsement



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

[This endorsement will be used to make the following types of administrative changes to the **Policy/Certificate** at the Policyholder's request:

1. Policyholder's Name or Address;
2. Addition or deletion of subsidiaries or affiliates of the Policyholder;
3. Changes to the class(es) of eligible persons;
4. Addition or deletion of Coverage(s);
5. Increase or decrease in Coverage Amount(s);
6. Addition or deletion of Benefit Riders;
7. Increase or decrease in Benefit Amount(s); or
8. Renewal of the Policy.]

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

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



ZURICH[®]

Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children 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 Group Accident Policy/Certificate.

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

If [a **Covered Person**] [an **Insured**] selects a **Plan** covering his or her eligible **Dependent Child(ren)**, and a covered **Dependent Child** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental [Dismemberment] [and Covered Loss of Use] [and Plegia] Coverage, **We** will pay the [**Covered Person**][**Insured**] an additional benefit which will be equal to the amount provided by the Accidental [Dismemberment] [and Covered Loss of Use] [and Plegia] Coverage.

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

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

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

After School Care Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**][an **Insured**] [selects a **Plan** covering his or her [**Dependents**][**Dependent Child(ren)**] and the [**Insured**][**Covered Person**] or his or her **Spouse**[/**Domestic Partner**] suffers a **Covered Injury** resulting in a **Covered Loss** which is payable under the [Accidental Death [and Dismemberment] Coverage, **We** will reimburse the charges actually incurred by the [**Insured**] [**Covered Person**] for the after school care for each **Dependent Child**, who at the time of the **Covered Loss** is [ten (10)] years old or less, up to the amount shown on the Schedule.

The after school care provider may not be **Related** to the [**Covered Person**][**Insured**] and proof acceptable to **Us** must be provided with the Proof of Covered Loss to establish eligibility for this benefit.

[If the [a **Covered Person**][an **Insured**]and his or her [**Spouse**][**Domestic Partner**] both die as a result of the same **Covered Injury**, and **We** pay an [Accidental Death] **Principal Sum** amount for both **Covered Persons**, only the **Insured's Principal Sum** will be used to calculate the amount applicable under this benefit.]

This benefit will be paid each year for [four (4)] consecutive years following the **Covered Loss** if the **Dependent Child(ren)** [is][are] under age [ten (10)] at the time of each payment.]

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

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

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

Inflation Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] sustains a **Covered Injury** that results in a **Covered Loss** payable under the [Accidental Death [and Dismemberment]] Coverage, the Inflation Benefit will provide an inflation adjustment to the **Principal Sum**.

The Inflation Benefit is the [**Covered Person's**] [**Insured's**] amount of **Principal Sum**, at the time of claim, multiplied by the product of:

1. the Inflation Benefit Percentage as shown on the Schedule; and
2. one (1) Credited Year for every 2 years of continuous coverage under the **Policy** prior to the **Covered Loss**; to a maximum of [ten (10)] multiplied by the injured **Covered Person's** amount of original **Principal Sum**. [(Principal Sum) x (Benefit Percentage x Years of Credited Coverage) = Inflation Benefit amount.]

[If [a **Covered Person**] [an **Insured**] increases the **Principal Sum**, **We** will apply the Inflation Benefit separately to each additional increase under the **Policy**. Likewise, if [a **Covered Person**] [an **Insured**] decreases the **Principal Sum**, **We** will correspondingly reduce any Inflation Benefit that was previously increased.]

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

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

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

HIV Occupational Accident Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**][an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss** while performing his or her job related duties, which causes him or her to acquire and test positive within [365] days of the **Covered Accident** for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC), **We** will pay an HIV Occupational Accident Benefit. Such HIV Occupational Accident Benefit will be equal to the amount shown on the Schedule. The HIV Occupational Accident Benefit will be paid in [twenty-four (24)] equal monthly installments.

In order to receive the HIV Occupational Accident Benefit, the [**Covered Person**] [**Insured**] must:

1. submit a workers' compensation injury report to his or her employer within forty-eight (48) hours of the **Covered Accident**. If the [**Covered Person's**][**Insured's**] employer does not maintain workers' compensation insurance, the [**Covered Person**][**Insured**] must complete an **Accident** report on a form that **We** will provide. The completed **Accident** report must be approved by the [**Covered Person's**][**Insured's**] employer within forty-eight (48) hours of the **Covered Accident** and must be submitted to **Us** within five (5) days of the **Covered Accident**; and
2. submit to a blood test for HIV and/or AIDS and/or related complex (ARC) within forty-eight (48) hours of the **Covered Accident**, which is administered by a **Physician**. The blood test results must be sent directly to **Us**.

If the initial test is negative, and the [**Covered Person**][**Insured**] subsequently tests positive for HIV, AIDS or ARC within [365] days of the **Covered Accident**, **We** will begin monthly payments on the first of the month following receipt of the report indicating positive test results.

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

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

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

[Permanent] [Temporary] Total Disability Benefit



ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**][an **Insured**] suffers a **Covered Injury** that renders the [**Covered Person**][**Insured**] [permanently][temporarily] **Totally Disabled**, **We** will pay a [Permanent][Temporary] Total Disability Benefit provided that he or she becomes [permanently][temporarily] **Totally Disabled** within [365] days of the **Covered Injury**; and the **Total Disability** continues for [twelve (12)] consecutive months.

The [monthly] [lump sum] amount payable under this benefit will be equal to the amount shown in the Schedule. [These payments will cease at the earliest of the following:

1. **We** make [60] payments under this benefit;
2. the [**Covered Person**] [**Insured**] is no longer **Totally Disabled**; or
3. the [**Covered Person**] [**Insured**] dies.

Payments will begin on the first day after the **Benefit Waiting Period** and will continue for as long as the [**Covered Person**] is **Totally Disabled**, but will not exceed the **Benefit Period** of [sixty (60)] months.] As a condition of coverage, **We** must receive proof of continuing **Total Disability** on a regular basis.]

Successive periods of **Total Disability** arising out of the same **Covered Injury** will be considered one **Total Disability** if they are separated by a period of less than [six (6)] months.

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

[Benefit Period] means the time period, after the end of the **Benefit Waiting Period**, that benefits are payable under this benefit subject to any other restrictions or limitations in the **Policy**.

Benefit Waiting Period means the [thirty (30)] consecutive days at the start of a period of continuous **Total Disability** for which **We** will not pay benefits.]

Continuous Care means monthly monitoring and/or evaluation of the disabling condition by a **Physician**.

Total Disability (Totally Disabled) means disability that:

1. prevents [a **Covered Person**][an **Insured**] from performing the material and substantial duties of any occupation for which he or she is qualified by reason of education, training, or experience or if for a **Covered Person** whom is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the [**Covered Person**] [**Insured**] immediately prior to the **Covered Accident**; and
2. requires the **Continuous Care** and treatment of a **Physician**.

If the [**Covered Person**][**Insured**] does not adhere to the treatment plan the **Physician** prescribes relating to his or her disabling condition, the] [**Covered Person**][**Insured**] shall not qualify for the [Permanent][Temporary] Total Disability Benefit. The [**Covered Person**][**Insured**] shall not qualify for **Total Disability** if he or she engages in any activity, such as employment, that results in earned income.

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

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

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

Critical Burn Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of a **Covered Accident**, **We** will pay a benefit as shown in the Schedule provided:

1. [the [**Covered Person**] [**Insured**] received [second degree or higher] burns over at least [25%] of his or her body;] [and]
2. [within [365] days of the **Covered Accident**, the [**Covered Person**][**Insured**] has undergone reconstructive surgery to treat the burned areas of the body.]

The Critical Burn Benefit is an amount equal to the least of:

1. the actual cost for the expense of the reconstructive surgery;
2. the amount resulting from multiplying the injured person's amount of **Principal Sum** by the percentage of **Critical Burn**; or
3. the Maximum Amount for this Benefit as provided on the Schedule.

For purposes of this rider only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to a **Covered Injury** [that is a full-thickness or third-degree burn,] as determined by a **Physician**. [(A full- thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).]

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

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

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

Continuation of Insurance Benefit



ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If the **Insured** [selects a **Plan** covering his or her [**Spouse/Domestic Partner**]] [and] [**Dependent Child(ren)**] and the **Insured** suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Coverage, provided there are no premium payments in arrears, all benefits under this **Policy** that were in force on the date of the loss will continue with respect to the **Insured's** eligible **Dependents** for [365] days after the date of loss with no additional premium payments.

For purposes of this rider only, insurance for eligible **Dependents** terminates on the earliest of:

1. [365] days after the date of **Covered Loss**;
2. the first premium due date after the **Dependent** no longer qualifies as a **Covered Person**;
3. [for the covered **Spouse/Domestic Partner**], the date the covered **Spouse/Domestic Partner** reaches age [70].]

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

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

Day Care Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] [selects a **Plan** covering his or her **Dependents** and [a **Covered Person**] [an **Insured**]] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death Coverage, **We** will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each covered **Dependent Child** if:

1. on the date of the **Covered Accident**, the covered **Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within [ninety (90)] days from the date of loss; and
2. the covered **Dependent Child** is under age [13].

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. [3%] of the **Principal Sum** of the [**Covered Person**] [**Insured**] who suffered the **Covered Loss**; or
3. [\$3,000].

[If both] [a **Covered Person**] [an **Insured**] and his or her covered **Spouse** [/**Domestic Partner**] suffer a simultaneous **Covered Loss** which is payable under the Accidental Death Coverage, the **Day Care Benefit** will be based on the **Insured's Principal Sum**.]

The **Day Care Benefit** will be paid annually for [four (4)] consecutive years if:

1. the covered **Dependent Child** is under age [13] at the time of each annual payment; and
2. proof, acceptable to **Us**, is received by **Us** that verifies that the covered **Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

For purposes of this rider only, an **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a **Hospital**; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

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**.

[The maximum amount payable under this benefit is [\$4,000].

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

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

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

Hearing Aid or Prosthetic Appliance Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] Coverage, **We** will pay an additional benefit provided:

1. the [**Covered Person**] [**Insured**] is required to use a Hearing Aid or **Prosthetic Appliance**;
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment Coverage is the same **Covered Injury** that requires the [**Covered Person**] [**Insured**] to use the Hearing Aid or **Prosthetic Appliance**; and
3. the Hearing Aid or **Prosthetic Appliance** was required within [365] days of the **Covered Injury**.

The amount **We** will pay will be equal to the one time cost of the Hearing Aid or **Prosthetic Appliance** actually paid by the [**Covered Person**] [**Insured**].

This benefit will not be paid unless:

1. the Hearing Aid or **Prosthetic Appliance** was prescribed by a **Physician** that is not **Related** to the [**Covered Person's**] [**Insured's**] **Spouse**[/**Domestic Partner**]; and
2. presentation of proof of payment is provided to **Us**.

For purposes of this rider only, **Prosthetic Appliance** means a replacement or artificial substitution for a missing body limb or eye. This does not include a dental prosthetic device such as dentures or crowns.

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of the **Principal Sum** of the [**Covered Person**] [**Insured**] that sustained the **Covered Injury** or [\$10,000].

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

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

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



ZURICH®

Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

[EMERGENCY TRANSPORTATION BENEFIT

If [Covered Person][an Insured] suffers a **Covered Injury** that requires **Emergency Treatment** within [12, 24, 48] hours of the date of the **Covered Accident** that caused the **Covered Injury** and it is determined that it is **Medically Necessary** that such [Covered Person][Insured] be transported to a **Hospital** or a **Satellite Emergency Center** by **Ambulance**, **We** will pay 100% of the Emergency Transportation Maximum Amount shown in the Schedule. Only one Emergency Transportation Benefit is payable for any one **Covered Accident** per [Covered Person][Insured]. [The maximum number of Emergency Transportation Benefits payable per calendar year per [Covered Person][Insured] regardless of the number of **Accidents** incurred, is shown in the Schedule.]]

[EMERGENCY TREATMENT BENEFIT

If [a Covered Person][an Insured] suffers a **Covered Injury** that, within [24,48,72] hours of the date of the **Covered Accident** that caused the **Covered Injury**, requires him or her to receive **Medically Necessary Emergency Treatment** in a **Hospital** emergency room or a **Satellite Emergency Center**, **We** will pay 100% [of the applicable] Emergency Treatment Benefit Maximum Amount shown in the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one **Covered Accident** per [Covered Person][Insured]. [The maximum number of Emergency Treatment Benefits payable per calendar year per [Covered Person][Insured] regardless of the number of **Covered Accidents** incurred, is shown in the Schedule.]]

[If an [Covered Person][Insured] requires both Emergency Transportation and **Emergency Treatment** due to the same **Covered Accident**, only one amount, the highest, will be paid.] [A maximum of [2] Emergency Transportation Benefits or Emergency Treatment Benefits are payable per [Covered Person][Insured] per calendar year regardless of the number of **Covered Accidents** incurred in that same calendar year.]

EMERGENCY HOSPITAL CASH

If the [Covered Person][Insured] is **Hospital Confined** due to **Covered Injury**, **We** will pay a daily allowance according to the actual days in **Hospital** up to the maximum benefit of 30 days. [**We** will not pay any claim for the first [3] calendar days of each emergency **Hospital Confinement** within the United States.]

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

[**Ambulance** means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded.

Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

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 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 (Hospital Confined) 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 the [**Covered Person**] [**Insured**] 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 an [**Emergency Treatment**] [or] [Emergency Transportation] is:

1. essential for the diagnosis, treatment and care of the **Covered Injury**;
2. meets generally accepted standards of medical practice; [or]
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision or order; or
4. [with regard to Emergency Transportation, is subsequently authorized by a **Physician** as appropriate due to the nature of the **Covered Injury**].

Satellite Emergency Center means a licensed facility providing outpatient care under the direction of a **Physician** on a twenty four (24) hour basis. Available services must include:

1. diagnostic care, including laboratory services and diagnostic x-rays; and
2. treatment or medical care, including availability of the means for stabilization of emergency medical conditions.

A **Satellite Emergency Center** does not include a **Hospital** or an office maintained by a **Physician** for the practice of medicine or dentistry).

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

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

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

Traumatic Brain Injury Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Traumatic Brain Injury** within [90] days of the date of **Covered Accident** which:

1. requires that [a **Covered Person**] [an **Insured**] be **Hospitalized** for at least [7] days during the first [90] days following the **Covered Accident**; and
2. continues for [9] consecutive months.

We will pay a Traumatic Brain Injury Benefit.

This Benefit will be paid: after **We** receive Proof of Loss in accordance with the Proof of Loss provision of the **Policy**.

The Traumatic Brain Injury Benefit is equal to the **Principal Sum** of the **Covered Person** that sustained the **Covered Injury**.

[**We** will not pay this benefit if a benefit is payable to [a **Covered Person**] [an **Insured**] for loss of life under the Accidental Death [and Dismemberment] Coverage].

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

Hospital or **Hospitalized** means admission to 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**.

Traumatic Brain Injury means physical damage to the brain which is certified by a **Physician** at the end of [9] consecutive months to be:

1. permanent, complete and irreversible; and
2. prevents the injured person from performing all the substantial and material functions and activities of a person of like age and gender in good health.

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

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

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

Home Alteration and Vehicle Modification Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the [Accidental Death [and Dismemberment] [and] [Covered Loss of Use][and Plegia] Coverage, **We** will pay an additional benefit for home alterations and vehicle modifications, provided:

1. the [**Covered Person**] [**Insured**] is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Covered Injury** that caused the payment of the [Accidental Death [and Dismemberment] [and] [Covered Loss of Use][and Plegia] Coverage is the same **Covered Injury** that requires the [**Covered Person**] [**Insured**] to use the wheelchair.

The amount **We** will pay will be equal to the one time cost of:

1. home alterations to the [**Covered Person's**] [**Insured's**] primary residence to make it wheelchair accessible and habitable; and
2. vehicle modifications necessary to his or her primary use motor vehicle to make the vehicle accessible or driver-side modification for wheelchair use.

For purposes of this rider only, benefits will not be payable unless:

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

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of the **Principal Sum** of the [**Covered Person's**] [**Insured's**] that sustained the **Covered Injury** or [\$10,000].

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

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

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

Natural Disaster Benefit



ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Death [and Dismemberment] [and Covered Loss of Use] [and Plegia] Coverage, **We** will pay a benefit equal to the lesser of [10%] of the [**Covered Person's**] [**Insured's**] **Principal Sum** or [\$10,000], provided the [**Covered Person**] [**Insured**] suffers the **Covered Injury** as a direct result of a **Natural Disaster**.

For purposes of this rider only, **Natural Disaster** means a weather event such as a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event, that arises from natural causes without direct human involvement and results in severe and widespread damage.

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

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

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



ZURICH®

[Occupational] [or] [Volunteer Activity] Hepatitis Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] tests positive for **Hepatitis** within [365] days of the date of an [**Occupational Incident**] [or] [**Volunteer Activity**], **We** will pay the benefit amount shown on the Schedule to the [**Covered Person**][**Insured**]. The benefit is payable if, within seventy-two (72) hours of the [**Occupational Incident**] [or] [**Volunteer Activity**], the [**Covered Person**][**Insured**]:

1. reports the [**Occupational Incident**] [or] [**Volunteer Activity**] to **Us** and the **Policyholder** in writing; and
2. undergoes a Food and Drug Administration (FDA) approved preliminary screening test for **Hepatitis** which indicates negativity with respect to the presence of any antibodies or antigens to such disease.

We must receive written notification of the test results from the laboratory which performed the test as soon as reasonably possible.

The benefit is payable monthly, starting on the last day of the month which immediately follows the month the [**Covered Person**] [**Insured**] tests positive for **Hepatitis**, for [127] consecutive months or until:

1. the date the [**Covered Person**] [**Insured**] dies; or
2. the date the [**Covered Person**] [**Insured**] recovers from **Hepatitis**, whichever occurs first.

If the [**Covered Person**] [**Insured**] tests positive for **Hepatitis** as a result of the same [**Occupational Incident**] [or] [**Volunteer Activity**], only one benefit amount, the largest, will be paid. **We** will not pay for any expenses incurred for testing.

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

Hepatitis means inflammation of the liver caused by a virus or a toxin. **Hepatitis** includes **Hepatitis** [A,] B, C, D and E.

[**Occupational Incident(s)**], means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the [**Covered Person**] [**Insured**] is performing Occupational services. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.]

[**Volunteer Activity (Volunteer Activities)**] means a **Covered Accident** resulting in exposure to **Hepatitis** which occurs while the [**Covered Person**] [**Insured**] is performing services as a volunteer. The exposure must be either:

1. cutaneous through abraded skin;
2. percutaneous; or
3. mucocutaneous.]

This rider only provides benefits for [**Occupational Incidents**] [or] [**Volunteer Activity**] as defined above.

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

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

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

Recuperation Benefit



ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss** and the [**Covered Person**] [**Insured**] is eligible to receive benefits payable under the [In-Hospital Indemnity Benefit] of the **Policy**, **We** will pay an additional Recuperation Benefit.

The Recuperation Benefit is equal to the amount shown on the Schedule and will be paid for the same [period of time as the] [number of days as was actually paid for the] [In-Hospital Indemnity Benefit].

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

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

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



ZURICH®

Student [Tuition] [and] [Expense] Reimbursement 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 Group Accident Insurance Policy/Certificate.

[Student Loan Reimbursement

If [a **Covered Person**][an **Insured**] that is a **Tuition Payor** suffers a **Covered Injury** resulting in a **Covered Loss** that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] Coverage, **We** will pay the **Covered Person's** outstanding loan balance incurred for **Student Tuition** as of date of the **Covered Loss** and owed to a financial institution or federal government for **Academic Studies**. The most **We** will pay is up to the benefit amount shown on the Schedule.]

[Tuition Reimbursement

If [a **Covered Person**] [an **Insured**] enrolled in **Academic Studies** suffers a **Covered Loss** that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] Coverage and which prevents the [**Covered Person**][**Insured**] from continuing to participate in it's **Academic Studies**, **We** will pay a **Tuition Expense** benefit as shown on the Schedule.]

[Student Tuition and Tuition Expenses

If [a **Covered Person**][an **Insured**] that is a **Tuition Payor** suffers a **Covered Loss** that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] Coverage and there is an obligation to pay **Student Tuition** to the **Policyholder** on behalf of the **Covered Person**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual **Student Tuition** and **Tuition Expenses**, or [(10%)].]

[Student Expenses

If [a **Covered Person**][an **Insured**] that is a **Tuition Payor** suffers a **Covered Loss** that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] Coverage and prevents the **Tuition Payor** from continuing to pay the **Student Expenses** incurred by the **Covered Person** for **Academic Studies**, **We** will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual **Student Expenses** or [(10%)].]

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

Eligibility of Covered Person. At the time of the **Covered Loss**, the **Covered Person** must be enrolled as a full-time student or have already been accepted by an accredited university, college, charter school, private school, magnet school, parochial school, or other such similar school where a **Tuition Expense** is incurred for **Academic Studies**.

Payment of Claims. Unless otherwise requested by the **Insured**, the [Accidental Death [and Dismemberment]] [Critical Illness] Coverage will be paid directly to the **Covered Person** or beneficiary up to the total amount of actual [**Tuition Expense**] [and] [**Student Expenses**] due from the **Tuition Payor**. Any payment made in good faith will release **Us** from any liability to the extent of the payment.

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

Academic Studies means the full-time attendance at an educational institution or school for the purpose of advancing education and for which the **Tuition Payor** incurred **Student Tuition** [and room and board (if supplied by the university, college or trade school)] to attend.

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

Spouse[/Domestic Partner] and/or **Dependent Child(ren)** designated by the **Insured** as enrolled in **Academic Studies** regardless of the **Plan** chosen by the **Insured**.]

Student Expense means those fees and expenses incurred or that would have been incurred by the **Tuition Payor** on behalf of a **Covered Person** for housing, transportation, and meal plan as charged by a school.

Student Tuition means the amount of money paid or to be paid, including administrative fees, by the **Tuition Payor** to an educational institution or school, including grammar schools, high schools, trade schools, university, or college. **Student Tuition** does not include housing or other living expenses.

Tuition Expenses means the actual unreimbursed amount of **Student Tuition** incurred or that would have been incurred by the **Tuition Payor** on behalf of a **Covered Person** to attend the school for **Academic Studies** including expenses incurred for learning material such as books.

Tuition Payor means the person(s) or individual(s) named or designated in the Application or Enrollment form as the person(s) or individual(s) that is/are financially responsible for paying the **Tuition Expenses** for the **[Covered Person][Insured]** that is a full-time student of the educational institute or school of the **Policyholder**.

[For purposes of this rider only, the following additional exclusions apply. Coverage does not apply to:

1. [Expenses previously reimbursed to the **Tuition Payor** or **Covered Person** through any employment tuition reimbursement program.]
2. [Academic Scholarships provided to the **Covered Person**.]
3. [Athletic Scholarships provided to the **Covered Person**.]
4. [Student loans made by the **Policyholder** to or on behalf of the **Tuition Payor** or the **Covered Person**. This does not include student loans made by a third party and facilitated by the **Policyholder**.]

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

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

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

Accelerated Payment Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

In the event that [a **Covered Person**][an **Insured**] is **Terminally Injured**, the [a **Covered Person**][an **Insured**] may be eligible to receive an Accelerated Payment Benefit (Accelerated Benefit). **We** will pay the applicable Accelerated Benefit amount as shown on the Schedule, provided the **Terminally Injured [Covered Person][Insured]**:

1. is covered under the **Policy**;
2. is under age [60]; and
3. provides Proof of Loss to **Us** of such **Terminal Injury**.

The [**Covered Person**][**Insured**] must request in writing that a portion of the **Terminally Injured** person's amount of Accidental Death Coverage be paid as an Accelerated Benefit. However, if the [**Covered Person**][**Insured**] is incompetent or unable to provide a request for the Accelerated Benefit, the [**Covered Person's**][**Insured's**] legal guardian may submit the request. The amount of Accidental Death Coverage payable upon the **Terminally Injured [Covered Person's][Insured's]** death will be reduced by any amount paid under this benefit.

The [**Covered Person**][**Insured**] may request a minimum Accelerated Benefit amount of [\$3,000, and a maximum of \$100,000]. However, in no event will the Accelerated Benefit Amount exceed [30%] of the **Terminally Injured** person's **Principal Sum** of Accidental Death Coverage. [This option may be exercised only once for each [**Covered Person**][**Insured**].] The Accelerated Benefit payment will be made to the [**Covered Person**][**Insured**] now instead of the [**Covered Person's**] [**Insured's**] beneficiary upon death.

[For example, if the [**Covered Person**][**Insured**] is covered for an Accidental Death [and Dismemberment] Benefit under the **Policy** of \$100,000 and is **Terminally Injured**, the [**Covered Person**][**Insured**] can request any portion of the amount of Accidental Death Coverage from \$3,000 to \$30,000 to be paid now instead of to the [**Covered Person's**][**Insured's**] beneficiary upon death. However, if the [**Covered Person**][**Insured**] decides to request only \$3,000 now, the [**Covered Person**][**Insured**] cannot request the additional \$27,000 in the future]. Any benefits received under this benefit may be taxable. The [**Covered Person**][**Insured**] should consult a personal tax advisor for further information.

The [**Covered Person**][**Insured**] will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit. If the [**Covered Person**][**Insured**] has executed an assignment of rights and interest with respect to the [**Covered Person's**][**Insured's**] Accidental Death Coverage, in order to receive the Accelerated Benefit, **We** must receive a release from the assignee before any benefits are payable.

We reserve the right to require satisfactory proof of **Terminal Injury** on an ongoing basis. Any diagnosis submitted must be provided by a **Physician** licensed to practice in the United States.

If the [**Covered Person**][**Insured**] does not submit Proof of Loss of **Terminal Injury**, or if the [**Covered Person**][**Insured**] refuses to be examined by a **Physician** as **We** may require, then **We** will not pay an Accelerated Benefit. If the [**Covered Person**][**Insured**] is diagnosed by a **Physician** as no longer **Terminally Injured** and:

1. are in an Eligible Class, coverage will remain in force, provided premium is paid;
2. are not in an Eligible Class, but the [**Insured**][**Covered Person**] continues to meet the definition of **Disabled**, coverage will remain in force, subject to the Change or Waiver condition within the **Policy**; and
3. Accelerated Benefit amounts previously paid to the [**Insured**][**Covered Person**] must be returned.

In any event, the amount of Accidental Death coverage will be reduced by the Accelerated Benefit paid.

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

Disabled means that due to the **Terminal Injury** the **[Covered Person][Insured]**:

1. is unable to perform the material and substantial duties of any occupation to which the **[Covered Person][Insured]** is suited by education, training, and experience; or
2. with respect to a **Spouse[Domestic Partner]** who is unemployed, his or her ability to engage in the normal and customary activities of a person of like age and gender in good health].

Terminal Injury or Terminally Injured means the **Covered Injury** suffered by the **[Covered Person] [Insured]** which resulted in the **[Covered Person][Insured]** having a life expectancy of [9] months or less.

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

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

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



ZURICH®

Accident Medical Expense - Indemnity Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [a **Covered Person**] [an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss** under this **Policy**, **We** will pay the following benefits as applicable per [Covered Person] [Insured] for each **Covered Accident**. The **Covered Injury** must be independent of **Sickness** or the medical or surgical treatment of **Sickness**, or of any cause other than a **Covered Accident**. A **Covered Loss** must also occur while coverage is in force.

[Emergency Room Treatment

We will pay [\$500] once per [48] hour period per **Covered Accident**, per [Covered Person] [Insured] when that [Covered Person] [Insured] receives emergency room treatment for **Injuries** sustained in a **Covered Accident**. This benefit is for treatment by a **Physician** or treatment received in a **Hospital** emergency room. Treatment must be received within [48] hours of the **Accident** for benefits to be payable.]

[X-Rays Related to an **Accident**

We will pay [\$500] once per **Covered Accident** per [Covered Person] [Insured] when a [Covered Person] [Insured] requires an X-ray while receiving emergency room treatment in a **Hospital** for **Injuries** sustained in a **Covered Accident**. This benefit is not for X-rays received in a **Physician's** office. [The X-Ray Benefit is not for exams listed in the Diagnostic Testing & Exams Benefit.]]

[Emergency Room Follow Up Treatment

We will pay [\$500] for one treatment per day, up to a maximum of [3] treatments per **Covered Accident** for each [Covered Person] [Insured] when that [Covered Person] [Insured] receives emergency room treatment for **Injuries** sustained in a **Covered Accident** and later requires additional treatment in addition to the original emergency room treatment administered in the first [48] hours following the **Covered Accident**. The emergency room follow up treatment must begin within [30] days of the **Covered Accident** or discharge from the **Hospital**, the **Hospital Confinement** which must be related to the same **Covered Accident** for which the subsequent treatment is being sought. Treatments must be furnished by a **Physician** in a **Physician's** office or in a **Hospital** on an outpatient basis. This benefit is not payable for days wherein additional emergency room treatment benefits are payable.]

[Accident Hospitalization

We will pay [\$500] once per period of **Hospital Confinement** or [\$500] once when a [Covered Person] [Insured] is admitted directly to an **Intensive Care Unit** [2] time(s) per calendar year per [Covered Person] [Insured] when that [Covered Person] [Insured] is admitted for a **Hospital Confinement** of at least [18] hours for treatment of **Injuries** sustained in a **Covered Accident** or if a [Covered Person] [Insured] is admitted directly to an **Intensive Care Unit** of a **Hospital** for treatment of **Injuries** sustained in a **Covered Accident**. **Hospital Confinements** must start within [60] days of the **Covered Accident**.]

[Specific Principal Sum Accidental Injuries

We will pay [\$500] for the following **Covered Injuries**:

[1. Dislocation Benefit

Dislocation (reduced under general anesthesia)

We will pay for no more than [2] **Dislocations** per **Covered Accident** per [Covered Person][Insured]. Benefits are payable for each **Dislocation** for each joint but for only the first **Dislocation** of a joint.

Benefit:

Joint Area	Open Reduction	Closed Reduction
A. Hip	[\$2,500]	[\$500]

B. Knee	[\$2,500]	[\$500]
C. Shoulder	[\$2,500]	[\$500]
D. Collar Bone	[\$2,500]	[\$500]
E. Ankle or Foot	[\$2,500]	[\$500]
F. Lower Jaw	[\$2,500]	[\$500]
G. Wrist	[\$2,500]	[\$500]
H. Elbow	[\$2,500]	[\$500]
I. Toe	[\$2,500]	[\$500]
J. Finger	[\$2,500]	[\$500]

If a **Dislocation** is reduced with local anesthesia, or no anesthesia by a **Physician** or a Physician Assistant, **We** will pay [50%] of the amount shown for the closed **Reduction Dislocation**.]

[2. Burn Benefit

For burns arising out of a **Covered Accident** and treated by a **Physician** within [48] hours after that **Covered Accident**, **We** will pay the following:

Benefit:

Body Surface Area	2 nd Degree	3 rd Degree
A. Less than 50 square centimeters	[\$2,500]	[\$5,000]
B. More than 100 but less than 150 square centimeters	[\$2,500]	[\$5,000]
C. More than 150 but less than 200 square centimeters	[\$2,500]	[\$5,000]
D. More than 200 but less than 250 square centimeters	[\$2,500]	[\$5,000]
E. More than 250 but less than 300 square centimeters	[\$2,500]	[\$5,000]
F. More than 300 square centimeters	[\$2,500]	[\$5,000]

[3. Skin Grafts

If [a **Covered Person**] [an **Insured**] receives up to [5] skin graft(s) for a burn from a **Covered Accident**, **We** will pay a total of [75%] of the Burn Benefit amount **We** paid for the burn involved in addition to the amount paid for the Burn Benefit.]

[4. Eye Injuries

If [a **Covered Person**][an **Insured**] sustains an **Injury** to an eye as a result of a **Covered Accident**, **We** will pay the following:

- a. Surgical repair [\$1,000]
- b. Removal of foreign body by a **Physician** [\$250].]

[5. Lacerations

If [a **Covered Person**] [an **Insured**] sustains a laceration as a result of a **Covered Accident**, provided the laceration is repaired within [48] hours after the **Covered Accident** and repaired under the attendance of a **Physician**, **We** will pay the following:

Benefit:

Laceration	Benefit Amount
A. Laceration(s) not requiring sutures and treated by a Physician (total length of all lacerations)	[\$500]
B. Laceration(s) less than 5 centimeters in length (total of all lacerations)	[\$500]
C. Lacerations at least 5 centimeters in length but not more than 15 centimeters in length (total of all lacerations)	[\$500]
D. Lacerations over 15 centimeters in length (total of all lacerations)	[\$500]

[6. Fractures

We will pay for no more than [5] **Fractures** per **Covered Accident**, per [Covered Person][Insured]. In the event of multiple fractures (more than [3]) sustained by the same [Covered Person][Insured], **We** will pay for the largest **Fracture** amount. However, **We** will pay [50%] of the benefit amount shown for the closed **Reduction** for **Chip Fractures** and other **Fractures** not reduced by Open or Closed **Reduction**.

Benefit:

Fracture Area	Open Reduction	Closed Reduction
A. Hip	[\$100]	[\$100]
B. Leg	[\$100]	[\$100]
C. Hand (excluding fingers)	[\$100]	[\$100]
D. Foot (excluding heel/toes)	[\$100]	[\$100]
E. Wrist	[\$100]	[\$100]
F. Kneecap	[\$100]	[\$100]
G. Lower Jaw	[\$100]	[\$100]
H. Shoulder	[\$100]	[\$100]
I. Vertebrae (body of)	[\$100]	[\$100]
J. Pelvis (excluding coccyx)	[\$100]	[\$100]
K. Sternum	[\$100]	[\$100]
L. Upper Jaw	[\$100]	[\$100]
M. Upper Arm	[\$100]	[\$100]
N. Face (excluding nose)	[\$100]	[\$100]
O. Rib	[\$100]	[\$100]
P. Nose	[\$100]	[\$100]
Q. Heel	[\$100]	[\$100]
R. Finger	[\$100]	[\$100]
S. Coccyx	[\$100]	[\$100]
T. Toe	[\$100]	[\$100]
U. Vertebral Processes	[\$100]	[\$100]
V. Skull		
i. Depressed	i. [\$100]	i. [\$100]
ii. Simple	ii. [\$100]	ii. [\$100]

[7. Concussion:

If [a **Covered Person**] [an **Insured**] sustains a concussion as a result of a **Covered Accident**, **We** will pay [\$100] for each concussion for each [**Covered Person**] [**Insured**].]

[8. Emergency Dental Procedure:

If [a **Covered Person**] [an **Insured**] sustains a **Covered Injury** as a result of a **Covered Accident** requiring emergency dental work, **We** will pay the following benefits:

- a. Broken tooth repaired with crown [\$75]
- b. Broken tooth resulting in extraction [\$75]

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. **We** will pay for no more than [2] Emergency Dental Procedure benefit(s) per **Covered Accident**, per [**Covered Person**] [**Insured**].]

[9. Specified Surgical Procedures Arising from a **Covered Accident**:

If [a **Covered Person**] [an **Insured**] sustains a **Covered Injury** as a result of a **Covered Accident** and one of the specified surgical procedures is required, such surgical procedure must be performed within [1] year(s) of the **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure.

Benefit:

Surgical Procedure	Benefit Amount
A. Arthroscopy without surgical repair	[\$25]
B. Open abdominal (including exploratory laparotomy)	[\$25]
C. Cranial	[\$25]
D. Hernia	[\$25]
E. Thoracic surgery	[\$25]
F. Repair of: <ul style="list-style-type: none"> i. Tendons and/or ligaments ii. Torn rotator cuffs iii. Ruptured discs iv. Torn knee cartilages 	[\$25]]

[10. Non-Specified Surgical Procedures Arising from a Covered Accident:

If [a **Covered Person**][an **Insured**] sustains a **Covered Injury** as a result of a **Covered Accident** and a non-specified surgical procedure is required, such surgical procedure must be performed within [one (1)] year of **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure. **We** will pay for the following:

- a. Miscellaneous surgery with general anesthesia [\$2,500]
- b. Other miscellaneous surgery with conscious sedation [\$2,500]]

[Diagnostic Testing & Exams Benefit

We will pay [\$2,500] [5 time(s)] per calendar year, per [Covered Person] [Insured] when a [Covered Person] [Insured] requires one of the following exams for **Injuries** sustained in **Covered Accident** and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a **Hospital** or a **Physician's** office. [Exams listed in the Diagnostic Testing & Exams Benefit are not covered under the X-Ray Related to an **Accident** Benefit.]

[Pain Management

We will pay [\$2,500] no more than [5 time(s)] per **Covered Accident**, per [Covered Person] [Insured] when a [Covered Person] [Insured] is prescribed, receives, and incurs a charge for an epidural or other similar treatment administered for pain management in a **Hospital** or a **Physician's** office for **Injuries** sustained in a **Covered Accident**. This benefit is not for an epidural or other similar treatment administered during a surgical procedure [or for pain management associated with pregnancy].]

[Physical Therapy and Rehabilitation

We will pay [\$25] per treatment for [2] treatment(s) per day, up to a maximum of [5] treatment(s) per **Covered Accident**, per [Covered Person] [Insured] when a [Covered Person] [Insured] receives emergency treatment for **Injuries** sustained in a **Covered Accident** and later a **Physician** advises [a **Covered Person**] [an **Insured**] to seek treatment from a licensed **Physical Therapist**. Physical therapy must be for **Injuries** sustained in a **Covered Accident** and must start within [30] days of the **Covered Accident** or discharge from the **Hospital**. The treatment must take place within [6] month(s) after the **Covered Accident**. [The Physical Therapy and Rehabilitation Benefit is not payable on the same day that the Emergency Room Follow Up Treatment Benefit is payable.]

[Durable Medical Equipment and Prosthetic Appliance

We will pay [\$5,000] once per **Covered Accident**, per [Covered Person] [Insured] when a [Covered Person] [Insured] receives **Durable Medical Equipment**, prescribed by a **Physician**, as an aid in personal locomotion for **Injuries** sustained in a **Covered Accident**. Benefits are for the following types of equipment: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches. **We** will pay [\$5,000] once per **Covered Accident** per [Covered Person] [Insured] when [a **Covered Person**] [an **Insured**] requires use of a **Prosthetic Appliance** as a result of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to provide a benefit for the repair or replacement of **Prosthetic Appliance** already prescribed for the **Covered Person**, hearing aids, wigs, or dental aids, including false teeth.]

[Blood, Plasma, and or Platelets

We will pay [\$2,500] once per **Covered Accident** per [Covered Person] [Insured] when that [Covered Person] [Insured] receives blood, plasma, and/or platelets for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to pay for immunoglobulins or other similar treatments.]

[Ambulance

We will pay [\$500] when a [Covered Person] [Insured] requires transportation by **Ambulance** and [\$2,500] when that [Covered Person] [Insured] requires air ambulance transportation to a **Hospital** for **Injuries** sustained in a **Covered Accident**. Air Ambulance services must take place within [48] hours of the **Covered Accident**. **Ambulance** transportation must be within [48] hours of the **Covered Accident**. A licensed professional ambulance company must provide the ambulance service. A licensed professional air ambulance company must provide the air ambulance service.]

[Transportation

We will pay [\$25] per round trip, up to three round trips per calendar year, per [Covered Person] [Insured] per round trip to a **Hospital** when a [Covered Person] [Insured] requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**. This benefit may also be used; if a covered **Dependent Child** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**, if commercial travel is necessary and such **Dependent Child** is accompanied by a person **Related** to the [Covered Person] [Insured]. This benefit is not for transportation to any **Hospital** located within a [50]-mile radius from the site of the **Accident** or the residence of the [Covered Person] [Insured]. The local attending **Physician** must prescribe the treatment requiring **Hospitalization** or **Hospital Confinement**, and the treatment must not be available locally. This benefit is not for transportation by ambulance or air ambulance to the **Hospital**.]

[Accommodations During Hospital Confinement

We will pay [\$50] per night, limited to one motel/hotel room per night, up to [5] days per **Covered Accident** for one motel/hotel room for a member of the immediate family who accompanies a [Covered Person] [Insured] who is admitted for **Hospitalization** or **Hospital Confinement** for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is only during the same period of time the injured [Covered Person] [Insured] is confined to the **Hospital**. The **Hospital** and motel or hotel must be more than [50] miles from the residence of the [Covered Person] [Insured].]

Limitations and Exclusions

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

1. We will not pay benefits for services rendered by a person **Related** to the [Covered Person] [Insured].
2. We will not pay benefits for treatment or loss due to **Sickness**, including
 - a. any bacterial, viral, or microorganism infection or infestation, or
 - b. any condition resulting from insect, arachnid, or other arthropod bites or stings; or
 - c. an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any **Sickness**.
3. We will not pay benefits for cosmetic surgery or other elective procedures that are not **Medically Necessary** or are unrelated to the **Injury** caused by the **Covered Accident**.
4. We will not pay benefits for dental treatment except as a result of a **Covered Injury**.

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

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

Chip Fracture means a **Fracture** in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a **Physician** through the use of an X-ray or other similar diagnostic exam.

Coma means a continuous state of profound unconsciousness, diagnosed or treated after the [Covered Person's] [Insured's] Effective Date of coverage, lasting for a period of seven or more consecutive days, and characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3)

vocalization. The condition must require intubation for respiratory assistance. **Coma** does not include medically induced coma.

Dislocation means a completely separated joint due to an **Injury**. The **Dislocation** must be diagnosed by a **Physician** [within 72 hours] after the date of the **Injury** and require correction by a **Physician**.

Durable Medical Equipment means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.

Fracture means a break in a bone due to an **Injury** and that can be seen by X-ray or other similar diagnostic exam. The **Fracture** must be diagnosed by a **Physician** [within 14 days after the date of the **Covered Injury**] and require correction by a **Physician**.

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 (Hospitalization) means a stay by the **[Covered Person]** **[Insured]** confined to a bed in a **Hospital** for which a room charge is made. The **Hospital Confinement** must be on the advice of a **Physician**, it must be **Medically Necessary**, and the result of **Injuries** sustained in a **Covered Accident** or for rehabilitative care and treatment for **Injuries** sustained in a **Covered Accident**. **Hospital Confinement** also means the period of **Hospital Confinement** that starts while this policy is in force. If the **Hospital Confinement** follows a previously covered **Hospital Confinement**, it will be deemed a continuation of the first **Hospital Confinement** unless (1) the later **Hospital Confinement** is the result of an entirely unrelated **Injury** or (2) the **Hospital Confinements** are separated by 30 days or more. **Hospitalization** that begins prior to the end of one calendar year and continues into the next calendar year will be considered one **Hospital Confinement**.

Injury means a bodily **Injury** caused directly by a **Covered Accident**, independent of **Sickness**, disease, bodily infirmity, or any other cause, occurring on or after the **[Covered Person's]** **[Insured's]** Effective Date of coverage and while coverage is in force for the **[Covered Person]** **[Insured]**.

Intensive Care Unit (ICU) means a specifically designated facility of the **Hospital** that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The **ICU** must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the **ICU** on a full-time basis. These units must be listed as **Intensive Care Units** in the current edition of the American Hospital Association Guide or be eligible to be listed therein. **ICU** includes Cardiac Intensive Care Units and Infant (Neonatal) Intensive Care Units.

Medically Necessary means that the medical service or treatment:

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

Physical Therapist means a licensed specialist in physical therapy other than a person **Related** to the **[Covered Person] [Insured]**.

Prosthetic Appliance means a replacement or artificial substitution for a missing body limb or eye. This does not include a dental prosthetic device such as dentures or crowns.

Reduction means open (surgical) or closed (manipulative) repair of a **Fracture** or **Dislocation**.

Rehabilitation Unit means a unit of a **Hospital** providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a **Physician** who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.

Sickness means an illness, disease, infection, or any other abnormal physical condition, independent of **Injury**, occurring on or after the **Insured's** Effective Date of coverage and while coverage is in force for the **Covered Person**. Complications of Pregnancy will be covered to the same extent as a **Sickness**.

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

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

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

Complications of Pregnancy Benefit



ZURICH AMERICAN INSURANCE COMPANY
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If a **Covered Person** suffers a **Covered Complications of Pregnancy**, [other than a **Non-elective Cesarean Section**,] resulting from a **Covered Accident**, **We** will pay the [coinsurance percentage of the] [**Usual and Customary**] expenses for **Medically Necessary** Covered Medical Service(s) incurred up to the Maximum Amount as shown on the Schedule. [The Maximum Amount is the amount payable per calendar year for all **Covered Complications of Pregnancy** payable under the **Policy**.] This benefit is payable only for such **Covered Charges** incurred [after the Deductible, as shown on the Schedule, has been met and] on or after the date the **Covered Person** suffers the **Covered Complications**. [**Complications of Pregnancy Benefits** are in excess of all other valid and collectible Insurance.]

[If the **Covered Complications of Pregnancy** are a **Medically Necessary Non-elective Cesarean Section**, after the applicable **Deductible** has been met and on or after the date the **Non-elective Cesarean Section** is performed, benefits are payable on the same basis as any other **Covered Complications** for **Covered Charges** incurred, up to the Maximum Amount shown in the Schedule.]

[Additional Benefit

If the **Covered Person's** coverage terminates under this benefit solely due to the birth of a child, an Additional Benefit will be provided for [six (6)] [weeks][months] from the date of termination for [**Covered Complications**] [and] [post-partum depression] resulting solely from that **Covered Accident**. This benefit is payable only for such **Covered Charges** incurred [after the applicable **Deductible**, as shown on the Schedule, has been met and] on or after the date the **Covered Person** suffers the **Covered Complications**, subject to the Additional Benefit Maximum Amount shown on the Schedule. [The overall Maximum Amount for **Complications of Pregnancy** payable per calendar year will be reduced by the amount paid under this Additional Benefit.] Benefits provided under this rider are subject to all other terms and limitations of the **Policy**.]

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

Alcohol and Substance Abuse means the overindulgence or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's welfare or the welfare of others.

Covered Complications of Pregnancy (Covered Complications) means any of the following conditions requiring [treatment by a **Physician**] [**Hospital Confinement**] [when the pregnancy is not terminated] whose diagnoses are distinct from but adversely affected by pregnancy or caused by pregnancy, including:

1. acute nephritis;
2. nephrosis;
3. cardiac decompensation;
4. missed abortion; [and]
5. similar medical and surgical conditions of comparable severity;[and]
6. [**Non-Elective Cesarean Section**]; [and]
7. spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Covered Complications of Pregnancy do not include false labor, occasional spotting, [**Physician**-prescribed rest during the period of pregnancy,] morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

[**Deductible** means the amount of **Usual and Customary** expenses for **Medically Necessary** treatment of [**Covered Complications**][**Non-elective Cesarean Sections**] that must be incurred and paid by [the **Covered Person**][**You**] before [**Covered Complications**][**Non-elective Cesarean Section**] benefits become payable. The amount of the **Deductible** is shown in the Schedule. **Covered Complications of Pregnancy** Benefits are not payable for charges applied to the **Deductible**.]

Durable Medical Equipment means equipment or apparatus of a type that is designed primarily for use, and used primarily, to assist persons suffering from illnesses or injuries that restrict their normal mobility and function and includes equipments such as a wheelchair or a hospital bed. It does not include items commonly used by persons that are not injured, even if the items can be used in the treatment of injury or can be used for rehabilitation or improvement of health such as a stationary bicycle or a spa.

Experimental or Investigative Treatment means treatment, a device or prescription medication which is recommended by a **Physician**, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device, or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any items requiring federal or other government agency approval for which approval is not yet received at the time the services are rendered.

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 (Hospital Confinement) means admission to a **Hospital** as an inpatient [for at least 24 consecutive hours] by a **Physician** for a **Covered Complication**. A **Hospital** stay that does not result in charges to 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 Complication** for which it is prescribed or performed;
2. meets generally accepted standards of medical practice; and
3. is ordered by a **Physician**.

[**Non-Elective Cesarean Section** means an unscheduled cesarean section due to an emergency which puts the life and health of the **Covered Person** or fetus in jeopardy.]

Pre-existing Condition means a condition for which 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 Complication [unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription].

[Usual and Customary Expense(s) (Covered Charges) means an amount(s) that: (1) is made for a **Covered Complication of Pregnancy**, (2) 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] (3) does not include charges that would not have been made if no insurance existed [and (4) 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.]

For purposes of this rider only, the term **Insured** is replaced by **Covered Person** wherever the **Insured** appears in the **Policy**, except with regard to Section II Eligibility and Effective Dates of Insurance and Section VII Termination of Insurance; Section VII B. Termination of **Covered Person's** Insurance is amended and replaced by the following:

B. Termination of **Covered Person's** Insurance.

[Insured. Insurance terminates at the end of the [month][date] for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. the **Insured** ceases to be eligible for insurance;
3. the **Insured** fails to pay the required premium, if the **Insured** is so required;
4. the birth of a child as a result of a **Covered Accident**;
5. [the **Insured** reaches age [70]];
6. [the **Insured** retires].]

[Insured. Insurance automatically terminates on the earliest of:

1. the date the **Policy** is terminated;
2. the date the **Insured** ceases to be eligible for insurance;
3. the expiration date of the period for which required premium has been paid for such **Insured**;
4. the date the **Insured** fails to pay the required premium, if the **Insured** is so required;
5. the date of the birth of a child as a result of a **Covered Accident**;
6. [the date the **Insured** reaches age [70]];
7. [the date the **Insured** retires].]

[If an **Insured** has received approval for a benefits eligible leave of absence, layoff or sabbatical from the **Policyholder** in accordance with the **Policyholder's** written **Policy**, his or her insurance under this **Policy** will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of this **Policy** with the exception of number 2. above.]

[Covered Person other than the **Insured.** Insurance terminates on the earliest of:

1. the date the insurance of the **Insured** terminates;
2. the first premium due date after the person no longer qualifies as a **Covered Person**;
3. the date of the birth of a child to the **Covered Person** as a result of a **Covered Accident**.
4. [for the Covered **Spouse/Domestic Partner**], the date the Covered **Spouse/Domestic Partner** reaches age [70].]

Termination of this **Policy** will not affect a claim for a covered loss that occurred while the **Covered Person's** coverage was in force under this **Policy**.

Termination of coverage will not affect a claim for a covered loss that occurred while the **Covered Person's** coverage was in force under this **Policy**.

EXCLUSIONS:

For purposes of this rider only, in addition to the General Exclusions in Section IV of the **Policy**, **We** will not provide coverage under this rider for any of the following:

- [1. routine examinations for pregnancy screening and testing.]
- [2. routine physical examination and related medical services.]
- [3. post-partum depression, except as specifically provided in the rider.]
- [4. rental of **Durable Medical Equipment** where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (if, in the **Company's** sole judgment, **Complications of Pregnancy** benefits for rental of **Durable Medical Equipment** are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the **Company** may, but is not required to, choose to consider such purchase expense as a **Covered Charge** in lieu of such rental expense).]
- [5. personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or guest meals while confined in a Hospital [or for items taken away or home from the Hospital, [including but not limited to crutches, wheel chairs and walkers] [except **Durable Medical Equipment**]].]
- [6. expenses incurred for psychological or psychiatric counseling of any kind or any expense for treatment of mental or nervous diseases or disorders.]
- [7. any expenses for a **Pre-existing Condition**.]
- [8. elective abortion.]
- [9. elective or cosmetic, plastic or restorative surgery.]
- [10. any condition for which the **Covered Person** is entitled to benefits under any mandatory no-fault automobile insurance.]
- [11. charges that are payable under automobile medical benefits [in excess of [\$5,000]].]
- [12. the cost of actual procedures relating to the testing, harvesting, and implantation of human eggs (oocytes).]
- [13. care, treatment, or services provided by any person **Related** to the **Covered Person**.]
- [14. **Experimental or Investigative Treatment** or procedures.]
- [15. diagnostic tests or treatment, except due to a **Complication of Pregnancy**.]
- [16. care, treatment or services provided by persons retained or employed by the **Policyholder**; or for supplies, prescriptions or medicines paid for or reimbursable for the **Policyholder**, or for which a charge is not made.]
- [17. normal pregnancy or child birth.]
- [18. treatment for a newborn child.]
- [19. treatment for in vitro fertilization, infertility, fertility studies, sexual transformation, sexual dysfunction.]
- [20. any expenses, services or treatment for any form of food supplement or augmentation (unless **Medically Necessary**), or for any exercise program for weight control, whether for obesity or any other diagnosis and whether by diet, injection of any fluid, or use of any medications or surgery of any kind.]
- [21. sexually transmitted diseases, including, but not limited to: herpes, gonorrhea, syphilis, cytomegalovirus, or any disability attributable, directly or indirectly, to Human Immunodeficiency Virus (HIV), and/or related illness including Acquired Immune Deficiency Syndromes (AIDS), or any mutant derivative thereof.]
- [22. non-prescription drugs which include, but are not limited to: vitamins, tonic, nutritional supplements, biochemical or herbal remedies.]
- [23. any loss incurred while outside the United States, its territories or Canada.]
- [24. **Alcohol and Substance Abuse**.]
- [25. riding in or driving any type of motor vehicle as part of a speed contest or scheduled race, including testing such vehicle on a track, speedway or proving ground.]
- [26. any action that may pose a health risk to the fetus, including, but not limited to: handling or changing cat litter, smoking cigarettes or remaining in the presence of secondhand smoke for extended periods of time.]
- [27. engaging in high-impact sports or any other similar activities that may pose a health risk to the fetus, including but not limited to: mountaineering, rappelling, horsemanship, rafting, sky-diving, bungee cord jumping.]

- [28. undergoing x-rays (except on an emergency basis) or chiropractic treatment without the prior written approval of a **Physician**.]
- [29. obtaining any permanent body tattooing or piercing any part of the **Covered Person's** body.]
- [30. use of any illegal drugs or use of any non-prescription medications or any prescription drug, narcotic, or hallucinogen, without consent of a **Physician** or in excess of the approved dosage]
- [31. **Complications of Pregnancy** arising from travel outside of the **Covered Person's** state of residence during the final trimester of pregnancy.]

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

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

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

SERFF Tracking Number: ZURC-127848523 *State:* Arkansas
Filing Company: Zurich American Insurance Company *State Tracking Number:* 50350
Company Tracking Number: CW AH 33801
TOI: H03G Group Health - Accidental Death & *Sub-TOI:* H03G.000 Health - Accidental Death &
Dismemberment Dismemberment
Product Name: Group Accident Policy - Additional Optional Riders
Project Name/Number: CW AH 33801 - Group Accident Policy - Additional Optional Riders/CW AH 33801

Comments:

Attachment:

U-GMC-104 -A CW Administrative Change Endorsement RED 10-03-11.pdf

Certificate of Readability



Zurich American Insurance Company

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

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

Form Number	Title	Flesch Score
U-GMC-104-B (09/11)	Administrative Change Endorsement	43
U-GMC-109-A (09/11)	Additional Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children Benefit	43
U-GMC-123-A (09/11)	After School Care Benefit	48
U-GMC-124-A (09/11)	Inflation Benefit	40
U-GMC-131-A (09/11)	HIV Occupational Accident Benefit	43
U-GMC-139-A (09/11)	[Permanent] [Temporary] Total Disability Benefit	38
U-GMC-141-A (09/11)	Critical Burn Benefit	51
U-GMC-147-A (09/11)	Continuation of Insurance Benefit	59
U-GMC-148-A (09/11)	Day Care Benefit	52
U-GMC-149-A (09/11)	Hearing Aid or Prosthetic Appliance Benefit	49
U-GMC-153-A (09/11)	Emergency [Transportation] [and] [Treatment] [and] Hospital Cash Benefit	34
U-GMC-161-A (09/11)	Traumatic Brain Injury Benefit	49
U-GMC-171-A (09/11)	Home Alteration and Vehicle Modification Benefit	40
U-GMC-172-A (09/11)	Natural Disaster Benefit	54
U-GMC-173-A (09/11)	[Occupational] [or] [Voluntary Activity] Hepatitis Benefit	32
U-GMC-174-A (09/11)	Recuperation Benefit	54
U-GMC-175-A (09/11)	Student [Tuition] [And] [Expense] Reimbursement Benefit	38
U-GMC-176-A (09/11)	Accelerated Payment Benefit	32
U-GMC-177-A (09/11)	Accident Medical Expense Indemnity Benefit	48
U-GMC-178-A (09/11)	Complications of Pregnancy Benefit	35

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:

A handwritten signature in black ink that reads 'Lisa Plante'.

Officer:

Lisa Plante

Title:

Head of A&H Product Management

Date:

November 7, 2011



Zurich American Insurance Company

**EXPLANATORY MEMORANDUM
Group Accident Insurance Policy Riders
Company Filing Number – CW AH 33801
U-GMC-100-A (08/09), et al**

Attached for your review are twenty (20) new riders for which we are seeking your approval to use with the Group Accident Insurance product previously filed with and authorized by your Department. As previously indicated, the Group Accident Insurance product and these new riders will be marketed to all statutorily eligible groups in your state consisting of two (2) or more individuals. Eligible groups shall include, but are not limited to: credit union groups; debtor groups; creditor groups; vendor groups; association groups; and financial institutions.

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

With the exception of our Administrative Change Endorsement, form U-GMC-104-B CW (09/11), these riders are new and are not intended to replace any other forms currently in use. Redlined and clean versions of the Administrative Change Endorsement are attached for your perusal.

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

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

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

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

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

Please note, for any association group that decides to purchase the Group Accident Insurance product, we will file copies of the corresponding association group's bylaws and articles of incorporation, as well as any other documentation required for approval by your Department prior to the association group's effective date of coverage.

Statement of Variables



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.

ADMINISTRATIVE CHANGE ENDORSEMENT – U-GMC-104-B CW (09/11)

<p>[This endorsement will be used to make the following types of administrative changes to the Policy/Certificate at the Policyholder's request:</p> <ol style="list-style-type: none">1. Policyholder's Name or Address;2. Addition or deletion of subsidiaries or affiliates of the Policyholder;3. Changes to the class(es) of eligible persons;4. Addition or deletion of Coverage(s);5. Increase or decrease in Coverage Amount(s);6. Addition or deletion of Benefit Riders;7. Increase or decrease in Benefit Amount(s); or8. Renewal of the Policy.]	<p>This endorsement will be used to make administrative changes to the Policy/Certificate.</p>
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ADDITIONAL ACCIDENTAL DISMEMBERMENT [AND COVERED LOSS OF USE] [AND PLEGIA] FOR DEPENDENT CHILDREN BENEFIT - U-GMC-109-A CW (09/11)

<p>If [a Covered Person][an Insured] selects a Plan covering his or her eligible Dependent Child(ren), and a Covered Dependent Child suffers a Covered Injury resulting in a Covered Loss, which is payable under the Accidental [Dismemberment] [and Covered Loss of Use] [and Plegia] coverage, We will pay the [Covered Person][Insured] an additional benefit which will be equal to the amount provided by the Accidental [Dismemberment] [and Covered Loss of Use] [and Plegia] Benefit.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[Dismemberment] [and Covered Loss of Use] [and Plegia] these will be in or out.</p> <p>[Dismemberment] [and Covered Loss of Use] [and Plegia] these will be in or out.</p> <p>[not] will be in or out.</p>
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AFTER SCHOOL CARE BENEFIT - U-GMC-123-A CW (09/11)

<p>If [a Covered Person][an Insured] [selects a Plan covering his or her [Dependents][Dependent Child(ren)] and the [Covered Person] [Insured] or his or her Spouse [Domestic Partner]] suffers a Covered Injury resulting in a Covered Loss which is payable under the [Accidental Death [and Dismemberment]] Coverage, We will reimburse the charges actually incurred for the after school care for each Dependent Child, who is [ten (10)] years old or less, up to the amount shown on the Schedule.</p> <p>[If the [Covered Person][Insured] and his or her [Spouse]/[Domestic Partner] both die as a result of the same Covered Injury, and We pay an [Accidental Death] Principal Sum amount on both [Covered Persons], only the Insured's Principal Sum will be used to calculate the amount applicable under this benefit.]</p> <p>This benefit will be paid each year for [four (4)] consecutive years if the Dependent Child(ren) [is][are] under age [ten (10)] at the time of each payment.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[selects a Plan covering his or her [Dependents] [Dependent Child(ren)] and the [Covered Person][Insured] or his or her Spouse [Domestic Partner]] will be in or out.</p> <p>If in, [Dependents][Dependent Child(ren)] will be in or out. If in, [Domestic Partner] will be in or out. [Accidental Death [and Dismemberment]] will be in or out. If in, [and Dismemberment]] will be in or out. [ten (10)] The range will be 4 – 15. The amount of reimbursement will range from \$100 - \$100,000.</p> <p>This will be in or out. If in: [Spouse]/[Domestic Partner] will be in or out. [Accidental Death] will be in or out.</p> <p>[four (4)] The range will be 1 – 8 [is][are] will be in or out. [ten (10)] The range will be 4 – 15</p> <p>[not] will be in or out.</p>
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HIV OCCUPATIONAL ACCIDENT BENEFIT - U-GMC-131-A CW (09/11)

<p>If [a Covered Person][an Insured] suffers a Covered Injury resulting in a Covered Loss while performing his or her job related duties, which causes him or her to acquire and test positive within [365] days of such Covered Accident for Human Immunodeficiency Virus (HIV) and/or AIDS and related complex (ARC), We will pay an HIV Occupational Accident Benefit. Such HIV Occupational Accident Benefit will be equal to the amount shown on the Schedule. The HIV Occupational Accident Benefit will be paid in [twenty-four (24)] equal monthly installments.</p>	<p>This will be in or out.</p> <p>[365] The range will be 30 - 720.</p> <p>[twenty-four (24)] The range will be 2 – 60.</p>
<p>If the initial test is negative, and the [Covered Person][Insured] subsequently tests positive for HIV, AIDS or ARC within [365] days of the Covered Accident, We will begin monthly payments on the first of the month following receipt of the report indicating positive test results.</p>	<p>[365] The range will be 30 - 720.</p>
<p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[not] will be in or out.</p>

[PERMANENT] [TEMPORARY] TOTAL DISABILITY BENEFIT U-GMC-139-A CW (09/11)

<p>[PERMANENT] [TEMPORARY] TOTAL DISABILITY BENEFIT</p> <p>If [a Covered Person][an Insured] suffers a Covered Injury that renders the [Covered Person][Insured] [permanently] [temporarily] Totally Disabled, We will pay a [Permanent] [Temporary] Total Disability Benefit provided that he or she becomes [permanently][temporarily] Totally Disabled within [365] days of the Covered Injury; and the permanent and Total Disability continues for [twelve (12)] months.</p> <p>The [monthly] [lump sum] amount payable under this benefit will be equal to the amount shown in the Schedule. [These payments will cease at the earliest of the following:</p> <ol style="list-style-type: none"> 1. We make [60] payments under this benefit; 2. the [Covered Person] [Insured] is no longer Totally Disabled; or 3. the [Covered Person] [Insured] dies. <p>Payments will begin on the first day after the Benefit Waiting Period and will continue for as long as the [Covered Person] is Totally Disabled, but will not exceed the Benefit Period of [sixty (60)] months.] As a condition of coverage, We must receive proof of continuing Total Disability on a regular basis.</p> <p>Successive periods of Total Disability arising out of the same Covered Injury will be considered one Total Disability if they are separated by a period of less than [six (6)] months.</p> <p>[Benefit Period means the time period, after the end of the Benefit Waiting Period, that benefits are payable under this benefit subject to any other restrictions or limitations in the Policy.</p> <p>Benefit Waiting Period means the [thirty (30)] consecutive days at the start of a period of continuous Total Disability for which We will not pay benefits.]</p> <p>If the [Covered Person][Insured] does not adhere to the treatment plan the Physician prescribes relating to his or her disabling condition, the [Covered Person][Insured] shall not qualify for the [Permanent][Temporary] Total Disability Benefit. The [Covered Person][Insured] shall not qualify for Total Disability if he or she engages in any activity, such as employment, that results in earned income.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[PERMANENT] [TEMPORARY] will be in or out</p> <p>[permanently] [temporarily] will be in or out. [Permanent] [Temporary] will be in or out.</p> <p>[permanently] [temporarily] will be in or out. [365] Range will be 90-730 [twelve (12)] Range will be 6 - 12</p> <p>[monthly] [lump sum] will be in or out.</p> <p>This will be in or out. If in:</p> <p>[60] Range will be 6 – 60</p> <p>[sixty (60) months] Range will be 6 - 60</p> <p>[six (6)] Range will be 3 - 12.</p> <p>This will be in or out.</p> <p>[thirty (30)] The range will be 0-365 days</p> <p>[Permanent] [Temporary] will be in or out.</p> <p>[not] will be in or out.</p>
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CRITICAL BURN BENEFIT - U-GMC-141-A CW (09/11)

If [a **Covered Person**][an **Insured**] suffers a **Covered Injury** that is a **Critical Burn** resulting in a **Covered Loss** as a result of a **Covered Accident**, **We** will pay a benefit as shown on the Schedule, provided:

1. the [**Covered Person**][**Insured**] received [second degree or higher] burns over at least [25%] of his or her body; [and]
2. [within [365] days of the **Covered Accident**, the [**Covered Person**][**Insured**] has undergone reconstructive surgery to treat the burned areas of the body.]

For the purposes of this rider only, **Critical Burn** means cosmetic disfigurement of the surface of a body area due to a **Covered Injury** [that is a full-thickness or third-degree burn,] as determined by a **Physician**. [(A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation).]

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

[second degree or higher]. The severity of the burn will be inserted. [25%] the range will be 10% to 80%. [and] will be in or out.

This will be in or out. If in, [365] the range will be 90 - 365 days.

This will be in or out.
This will be in or out.

[not] will be in or out.

CONTINUATION OF INSURANCE BENEFIT U-GMC-147-A CW (09/11)

<p>If the Insured [selects a Plan covering his or her [Spouse[/Domestic Partner]] [and] [Dependent Child(ren)] and the [Insured] suffers a Covered Injury resulting in a Covered Loss, which is payable under the Accidental Death Coverage, provided there are no premium payments in arrears, all Coverages under this Policy which were in force on the date of the loss will continue with respect to the Insured's eligible Dependents for [365] days after the date of loss with no additional premium payments.</p> <p>For purposes of this rider only, insurance for eligible Dependents terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. [365] days after the date of Covered Loss; 2. the first premium due date after the Dependent no longer qualifies as a Covered Person; 3. [for the covered Spouse[/Domestic Partner], the date the covered Spouse[/Domestic Partner] reaches age [70].] 	<p>[selects a Plan covering his or her [Spouse[/Domestic Partner]] [and] [Dependent Child(ren)] and the Insured] These will be in or out.</p> <p>[365] The range will be 90 - 365.</p> <p>[365] The range will be 90 - 365.</p> <p>This will be in or out. If in, [/Domestic Partner] will be in or out. [70] the range will be 65 - 90.</p>
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DAY CARE BENEFIT - U-GMC-148 A CW (09/11)

<p>If [a Covered Person][an Insured] [selects a Plan covering his or her Dependents and [a Covered Person][an Insured]] suffers a Covered Injury resulting in a Covered Loss, which is payable under the Accidental Death Coverage, We will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each Dependent Child if:</p> <ol style="list-style-type: none"> 1. on the date of the Accident, the covered Dependent Child was enrolled in an Accredited Child Care Facility, or enrolls in such facility within [ninety (90)] days from the date of loss; and 2. the covered Dependent Child is under age [13]. <p>The Day Care Benefit will be equal to the lesser of:</p> <ol style="list-style-type: none"> 1. the actual cost of the child care; 2. [3%] of the Principal Sum of the [Covered Person][Insured] who suffered the Covered Loss; or 3. [\$3,000]. <p>[If both] [a Covered Person][an Insured] and his or her Covered Spouse[/Domestic Partner] suffer a simultaneous Covered Loss which is payable under the Accidental Death Coverage, the Day Care Benefit will be based on the Insured's Principal Sum.</p> <p>The Day Care Benefit will be paid annually for [four (4)] consecutive years if:</p> <ol style="list-style-type: none"> 1. the Dependent Child is under age [13] at the time of each annual payment; and 2. proof, acceptable to Us, is received by Us that verifies that the Dependent Child remains enrolled in an Accredited Child Care Facility. <p>The maximum amount payable under this benefit is [\$4,000].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[selects a Plan covering his or her Dependents] will be in or out.</p> <p>[ninety (90)] The range will be 30 - 365</p> <p>[13] The range will be 2 - 18</p> <p>[3%] The range will be 1% - 10%</p> <p>[\$3,000] The range will be \$500 - \$30,000</p> <p>[If both] will be in or out. [/Domestic Partner] will be in or out.</p> <p>[four (4)] The range will be 1 – 10</p> <p>[13] the range will be 2 – 18</p> <p>[\$4,000] the range will be \$500 - \$30,000.</p> <p>[not] will be in or out.</p>
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HEARING AID OR PROSTHETIC APPLIANCE BENEFIT – U-GMC-149-A CW (09/11)

If [a **Covered Person**][an **Insured**] suffers a **Covered Injury** resulting in a **Covered Loss**, which is payable under the Accidental Dismemberment [and Covered Loss of Use][and Plegia] coverage, **We** will pay an additional benefit provided:

1. the [**Covered Person**][**Insured**] is required to use a Hearing Aid or **Prosthetic Appliance**;
2. the **Covered Injury** that caused the payment of the Accidental Dismemberment Coverage is the same **Covered Injury** that requires the [**Covered Person**][**Insured**] to use the Hearing Aid or **Prosthetic Appliance**; and
3. the Hearing Aid or **Prosthetic Appliance** was required within [365] days of the **Covered Injury**.

This benefit will not be paid unless:

1. the Hearing Aid or **Prosthetic Appliance** was prescribed by a **Physician** that is not **Related** to the [**Covered Person's**] [**Insured's**] **Spouse**[/**Domestic Partner**]; and

The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of the **Principal Sum** of the [**Covered Person**] [**Insured**] that sustained the **Covered Injury** or [\$10,000].

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

[and Covered Loss of Use] will be in or out.
[and Plegia] will be in or out.

[365] The range will be 90 - 730.

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

[10%] The range will be 5% - 50%.

[\$10,000] The range will be \$1,000 - \$50,000.

[not] will be in or out.

**EMERGENCY [TRANSPORTATION] [AND] [TREATMENT] [AND] HOSPITAL CASH BENEFIT
U-GMC-153-A CW (09/11)**

<p>EMERGENCY [TRANSPORTATION] [AND] [TREATMENT] [AND] HOSPITAL CASH BENEFIT</p> <p>[EMERGENCY TRANSPORTATION BENEFIT If [Covered Person][an Insured] suffers a Covered Injury that requires Emergency Treatment within [12, 24, 48] hours of the date of the Covered Accident that caused the Covered Injury and it is determined that it is Medically Necessary that such [Covered Person][Insured] be transported to a Hospital or a Satellite Emergency Center by Ambulance, the Company will pay 100% of the Emergency Transportation Maximum Amount shown in the Benefit Schedule. Only one Emergency Transportation Benefit is payable for any one Covered Accident per [Covered Person][Insured]. [The maximum number of Emergency Transportation Benefits payable per calendar year per [Covered Person][Insured] regardless of the number of Accidents incurred, is shown in the Benefit Schedule.]]</p> <p>[EMERGENCY TREATMENT BENEFIT If [a Covered Person][an Insured] suffers a Covered Injury that, within [24, 48, 72] hours of the date of the Covered Accident that caused the Covered Injury, requires him or her to receive Medically Necessary Emergency Treatment in a Hospital emergency room or a Satellite Emergency Center, We will pay 100% [of the applicable] Emergency Treatment Benefit Maximum Amount shown in the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one Covered Accident per [Covered Person][Insured]. [The maximum number of Emergency Treatment Benefits payable per calendar year per [Covered Person][Insured] regardless of the number of Covered Accidents incurred, is shown in the Benefit Schedule.]]</p> <p>[If an [Covered Person][Insured] requires both Emergency Transportation and Emergency Treatment due to the same Covered Accident, only one amount, the highest, will be paid.] [A maximum of [2] Emergency Transportation Benefits or Emergency Treatment Benefits are payable per [Covered Person][Insured] per calendar year regardless of the number of Covered Accidents incurred in that same calendar year.]</p> <p>EMERGENCY HOSPITAL CASH If the [Covered Person][Insured] is Hospital Confined due to Covered Injury, We will pay a daily allowance according to the actual days in Hospital up to the maximum benefit of 30 days. [We will not pay any claim for the first [3] calendar days of each emergency Hospital Confinement within the United States.]</p> <p>For purposes of this rider only, the following additional</p>	<p>[TRANSPORTATION] [AND] [TREATMENT] [AND] will be in or out.</p> <p>This will be in or out. If in: [12, 24, 48] hours. One of these three choices will be inserted.</p> <p>This will be in or out.</p> <p>This will be in or out. If in: [24, 48, 72] hours. One of these three choices will be inserted.</p> <p>[of the applicable] will be in or out.</p> <p>[, the largest,] will be in or out. This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. If in: [2] the range will be 1 – 10.</p> <p>This will be in or out. If in: [3] the range will be 1 - 10.</p>
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definitions apply:

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. **Ambulance** does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

Hospital Confinement (Hospital Confined) 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 [the **Covered Person**][**Insured**] 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 an **[Emergency Treatment]** [or] **[Emergency Transportation]** is:

1. essential for the diagnosis, treatment and care of the Injury;
2. meets generally accepted standards of medical practice; [or]
3. is ordered by a **Physician** and performed under the **Physician's** care, supervision or order;[or]
4. with regard to Emergency Transportation, is subsequently authorized by a **Physician** as appropriate due to the nature of the **Covered Injury**].

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

This will be in or out.

[twenty-four (24)] The range will be 12 - 96.

[Emergency Treatment] will be in or out.
[or] will be in or out.
[Emergency Transportation] will be in or out.

[or] will be in or out.

This will be in or out.

[not] will be in or out.

TRAUMATIC BRAIN INJURY BENEFIT - U-GMC-161-A CW (09/11)

<p>If [a Covered Person] [an Insured] suffers a Covered Injury resulting in a Traumatic Brain Injury within [90] days of the date of Covered Accident which:</p> <ol style="list-style-type: none"> requires that [a Covered Person][an Insured] be Hospitalized for at least [7] days during the first [90] days following the Covered Accident; and continues for [9] consecutive months <p>We will pay a Traumatic Brain Injury Benefit.</p> <p>This Benefit will be paid: after We receive Proof of Loss in accordance with the Proof of Loss provision of the Policy.</p> <p>The Traumatic Brain Injury Benefit is equal to the Principal Sum of the Covered Person that sustained the Covered Injury.</p> <p>[We will not pay this benefit if a benefit is payable to [a Covered Person][an Insured] for loss of life under the Accidental Death [and Dismemberment] Coverage].</p> <p>Traumatic Brain Injury means physical damage to the brain which is certified by a Physician at the end of [9] consecutive months to be: (1) permanent, complete and irreversible; and (2) prevents the injured person from performing all the substantial and material functions and activities of a person of like age and gender in good health.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[90] the range will be 60 – 365 days</p> <p>[7] The range will be 7 -14 [90] The range will be 60 – 365 [9] The range will be 6 -12</p> <p>This will be in or out. If in: [and Dismemberment] will be in or out.</p> <p>[9] The range will be 6 -12.</p> <p>[not] will be in or out.</p>
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HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT - U-GMC-171-A CW (09/11)

<p>If [a Covered Person][an Insured] suffers a Covered Injury resulting in a Covered Loss, which is payable under the [Accidental Death][and Dismemberment] [and Covered Loss of Use][and Plegia] Coverage, We will pay an additional benefit for home alterations and/or vehicle modifications, provided:</p> <ol style="list-style-type: none"> 1. the [Covered Person] [Insured] is required to use a wheelchair to be ambulatory on a permanent basis; and 2. the Covered Injury that caused the payment of the [Accidental Death] [and Dismemberment] [and Covered Loss of Use][and Plegia] Coverage is the same Covered Injury that requires the [Covered Person][Insured] to need the wheelchair. <p>The maximum amount payable under all provisions of this benefit combined will be the lesser of [10%] of the Principal Sum of the [Covered Person's][Insured's] that sustained the Covered Injury or [\$10,000].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[Accidental Death] [and Dismemberment] [and Covered Loss of Use] [and Plegia] Each will be in or out.</p> <p>[Accidental Death] [and Dismemberment] [and Covered Loss of Use] [and Plegia] Each will be in or out.</p> <p>[10%] The range will be 1% - 50%.</p> <p>[\$10,000] The range will be \$1,000- \$50,000.</p> <p>[not] will be in or out.</p>
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NATURAL DISASTER BENEFIT U-GMC-172-A CW (09/11)

<p>If [a Covered Person][an Insured] suffers a Covered Injury resulting in a Covered Loss, which is payable under the Accidental Death [and Dismemberment] [and Covered Loss of Use] [and Plegia] Coverage, We will pay a benefit equal to the lesser of [10%] of the [Covered Person's][Insured's] Principal Sum or [\$10,000], provided the [Covered Person][Insured] suffers the Covered Injury as a direct result of a Natural Disaster.</p> <p>For purposes of this rider only, Natural Disaster means a weather event such as a storm (wind, rain, snow, sleet, hail, lightning, dust or sand), earthquake, flood, volcanic eruption, wildfire or other similar event, that arises from natural causes without direct human involvement and results in severe and widespread damage.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[and Dismemberment] [and Covered Loss of Use] [and Plegia] These will be in or out. [10%] The range will be 10% - 100%. [\$10,000] The range will be \$500 - \$50,000.</p> <p>[not] This will be in or out.</p>
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[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] HEPATITIS BENEFIT - U-GMC-173 A CW (09/11)

<p>[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] HEPATITIS BENEFIT</p>	<p>[OCCUPATIONAL] [OR] [VOLUNTEER ACTIVITY] These will be in or out.</p>
<p>If [a Covered Person][an Insured] tests positive for Hepatitis within [365] days of the date of the [Occupational Incident] [or] [Volunteer Activity], We will pay the benefit amount shown on the Schedule to the [Covered Person][Insured]. The benefit is payable if, within seventy-two (72) hours of the [Occupational Incident] [or] [Voluntary Activity] the [Covered Person][Insured]:</p>	<p>[365] The range will be 30 – 365. [Occupational Incident] [or] [Volunteer Activity] These will be in or out.</p>
<ol style="list-style-type: none">1. reports the [Occupational Incident] [or] [Volunteer Activity] to Us [and the Policyholder] in writing; and2. undergoes a Food and Drug Administration (FDA) approved preliminary screening test for Hepatitis which indicates negativity with respect to the presence of any antibodies or antigens to such disease.	<p>[Occupational Incident] [or] [Volunteer Activity] These will be in or out.</p>
<p>The benefit is payable monthly, starting on the last day of the month which immediately follows the month the [Covered Person][Insured] tests positive for Hepatitis, for [127] consecutive months or until: . . .</p>	<p>[Occupational Incident] [or] [Volunteer Activity] These will be in or out. [and the Policyholder] will be in or out.</p>
<p>If the [Covered Person] [Insured] tests positive for Hepatitis as a result of the same [Occupational Incident] [or] [Volunteer Activity], only one benefit amount, the largest, will be paid. We will not pay for any expenses incurred for testing.</p>	<p>[127] The range will be 1 - 180</p>
<p>Hepatitis means inflammation of the liver caused by a virus or a toxin. Hepatitis includes Hepatitis [A,] B, C, D and E.</p>	<p>[Occupational Incident] [or] [Volunteer Activity] These will be in or out.</p>
<p>[Occupational Incident(s), means a Covered Accident resulting in exposure to Hepatitis which occurs while the [Covered Person] [Insured] is performing Occupational services. The exposure must be either:</p> <ol style="list-style-type: none">1. cutaneous through abraded skin;2. percutaneous; or3. mucocutaneous.]	<p>[A,] will be in or out.</p>
<p>[Volunteer Activity (Volunteer Activities) means a Covered Accident resulting in exposure to Hepatitis which occurs while the [Covered Person] [Insured] is performing services as a volunteer. The exposure must be either:</p> <ol style="list-style-type: none">1. cutaneous through abraded skin;2. percutaneous; or3. mucocutaneous.]	<p>This will be in or out.</p>
<p>This rider only provides benefits for [Occupational Incidents] [or] [Volunteer Activity] as defined above.</p>	<p>This will be in or out.</p>
<p>This rider only provides benefits for [Occupational Incidents] [or] [Volunteer Activity] as defined above.</p>	<p>[Occupational Incident] [or] [Volunteer Activity] These will be in or out.</p>

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

[not] will be in or out.

RECUPERATION BENEFIT U-GMC-174-A CW (09/11)

<p>If [a Covered Person][an Insured] suffers a Covered Injury resulting in a Covered Loss and the [Covered Person][Insured] is eligible to receive benefits payable under the [In-Hospital Indemnity Benefit] of the Policy, We will pay an additional Recuperation Benefit.</p> <p>The Recuperation Benefit is equal to the amount shown on the Schedule and will be paid for the same [period of time as the] [number of days as was actually paid for the] [In-Hospital Indemnity Benefit].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>[In-Hospital Indemnity Benefit] This is to be replaced with other benefits that include a Hospital Confinement, as defined within those associated benefit riders.</p> <p>[period of time as the] [number of days as was actually paid for the] one of these will be included and the range will vary from \$25 to \$1,000 per day per Covered Person consistent with the benefit to which is inserted.</p> <p>[In-Hospital Indemnity Benefit] This is to be replaced with other benefits that include a Hospital Confinement, as defined within those associated benefit riders.</p> <p>[not] will be in or out.</p>
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STUDENT [TUITION] [AND] [EXPENSE] REIMBURSEMENT BENEFIT U-GMC-175-A CW (09/11)

<p>STUDENT [TUITION] [AND] [EXPENSE] REIMBURSEMENT BENEFIT</p> <p>[Student Loan Reimbursement If [a Covered Person][an Insured] that is a Tuition Payor suffers a Covered Injury resulting in a Covered Loss that is payable under the [Accidental Death and Dismemberment][Critical Illness] Coverage, We will pay the Covered Person's outstanding loan balance incurred for Student Tuition as of date of the Covered Loss and owed to a financial institution or federal government for Academic Studies. The most We will pay is up to the benefit amount shown on the Schedule.]</p> <p>[Tuition Reimbursement If [a Covered Person][an Insured] enrolled in Academic Studies suffers a Covered Loss that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] Coverage and which prevents the [Covered Person][Insured] from continuing to participate in it's Academic Studies, We will pay a Tuition Expense benefit as shown on the Schedule.]</p> <p>[Student Tuition and Tuition Expenses If [a Covered Person][an Insured] that is a Tuition Payor suffers a Covered Loss that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] coverage and there is an obligation to pay Student Tuition to the Policyholder on behalf of the Covered Person, We will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual Student Tuition and Tuition Expense, or [(10%)].]</p> <p>[Student Expenses If [a Covered Person][an Insured] that is a Tuition Payor suffers a Covered Loss that is payable under the [Accidental Death [and Dismemberment]] [Critical Illness] coverage and prevents the Tuition Payor from continuing to pay the Student Expenses incurred by the Covered Person for Academic Studies, We will pay an annual benefit up to the maximum number of payments as shown on the Schedule. The benefit amount will increase annually by the lesser of the actual Student Expenses or [(10%)].]</p> <p>For purposes of this rider only, the following additional Conditions apply:</p> <p>Payment of Claims. Unless otherwise requested by the Insured, the [Accidental Death [and Dismemberment]]</p>	<p>[TUITION] [AND] [EXPENSE] will be in or out.</p> <p>This will be in or out. If in:</p> <p>[Accidental Death [and Dismemberment]] will be in or out. If in, [and Dismemberment] will be in or out. [Critical Illness] will be in or out.</p> <p>The benefit amount will range from \$100 per Covered Person per outstanding loan balance to \$100,000 for all Covered Person's outstanding loan balances in the aggregate.</p> <p>This will be in or out. If in:</p> <p>[Accidental Death [and Dismemberment]] will be in or out. If in, [and Dismemberment] will be in or out. [Critical Illness] will be in or out. The Tuition Expense amount will range from \$100 per Covered Person to \$500,000 for all Covered Persons in the aggregate.</p> <p>This will be in or out. If in:</p> <p>[Accidental Death [and Dismemberment]] will be in or out. If in, [and Dismemberment] will be in or out. [Critical Illness] will be in or out. The annual benefit will range from \$100 to \$50,000 per Covered Person and up to \$200,000 in the aggregate for all Covered Persons. The maximum number of payments will range from 1 to 16 per Covered Person. [(10%)] the benefit increase will vary from 0 to 100%.</p> <p>This will be in or out. If in:</p> <p>[Accidental Death [and Dismemberment]] will be in or out. If in, [and Dismemberment] will be in or out. [Critical Illness] will be in or out. The annual benefit will range from \$100 to \$50,000 per Covered Person and up to \$200,000 in the aggregate for all Covered Persons. The maximum number of payments will range from 1 to 16 per Covered Person. [(10%)] the range will vary from 0 to 100%.</p> <p>[Accidental Death [and Dismemberment]] will be in or out. If</p>
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[Critical Illness] coverage will be paid directly to the **Covered Person** or beneficiary up to the total amount of actual **[Tuition Expense]** [and] **[Student Expenses]** due from the **Tuition Payor**. Any payment made in good faith will release **Us** from any liability to the extent of the payment.

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

Academic Studies means the full-time attendance at an educational institution or school for the purpose of advancing education and for which the **Tuition Payor** incurred **Student Tuition** [and room and board (if supplied by the university, college or trade school)] to attend.

[Covered Person] means any person who has insurance under the terms of this **Policy**. It includes the **Insured** [,and his or her **Spouse[/Domestic Partner]** and/or **Dependent Child(ren)** if a **Plan** covering the **Spouse [/Domestic Partner]** and/or **Dependent Child(ren)** is selected. **Covered Person** also includes the **Spouse[/Domestic Partner]** and/or **Dependent Child(ren)** designated by the **Insured** as enrolled in **Academic Studies** regardless of the **Plan** chosen by the **Insured**.]

[For purposes of this rider only, the following additional exclusions apply. Coverage does not apply to:

1. [Expenses previously reimbursed to the **Tuition Payor** or **Covered Person** through any employment tuition reimbursement program.]
2. [Academic Scholarships provided to the **Covered Person**.]
3. [Athletic Scholarships provided to the **Covered Person**.]
4. [Student loans made by the **Policyholder** to or on behalf of the **Tuition Payor** or the **Covered Person**. This does not include student loans made by a third party and facilitated by the **Policyholder**.]

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

in, [and Dismemberment] will be in or out. **[Critical Illness]** will be in or out. **[Tuition Expense]** [and] **[Student Expenses]** will be in or out.

This will be in or out.

This will be in or out. If in,

This will be in or out. If in, **[/Domestic Partner]** will be in or out. **[/Domestic Partner]** will be in or out.

[/Domestic Partner] will be in or out.

This will be in or out. If in:

Exclusions 1 – 4 will be in or out.

[not] will be in or out.

ACCELERATED PAYMENT BENEFIT - U-GMC-176-A CW (09/11)

In the event that [a **Covered Person**][an **Insured**] is **Terminally Injured**, the [**Covered Person**][**Insured**] may be eligible to receive an Accelerated Payment Benefit (Accelerated Benefit). **We** will pay the applicable Accelerated Benefit amount as shown on the Schedule, provided the **Terminally Injured** [**Covered Person**][**Insured**]:

1. is covered under the **Policy**;
2. is under age [60]; and
3. gives Proof of Loss to **Us** of such **Terminal Injury**.

The [**Covered Person**][**Insured**] may request a minimum Accelerated Benefit amount of [\$3,000, and a maximum of \$100,000]. However, in no event will the Accelerated Benefit Amount exceed [30%] of the **Terminally Injured** person's **Principal Sum** of Accidental Death Coverage. [This option may be exercised only once for each [**Covered Person**][**Insured**].] The Accelerated Benefit payment will be made to the [**Covered Person**][**Insured**] now instead of the [**Covered Person's**][**Insured's**] beneficiary upon death.

[For example, if the [**Covered Person**][**Insured**] is covered for an Accidental Death [and Dismemberment] Benefit under the **Policy** of \$100,000 and is **Terminally Injured**, the [**Covered Person**][**Insured**] can request any portion of the amount of Accidental Death Coverage Amount from \$3,000 to \$30,000 to be paid now instead of to the [**Covered Person's**][**Insured's**] beneficiary upon death. However, if the [**Covered Person**][**Insured**] decides to request only \$3,000 now, the [**Covered Person**][**Insured**] cannot request the additional \$27,000 in the future].

Disabled means that due to the **Terminal Injury** the [**Covered Person**] [**Insured**]:

1. is unable to perform the material and substantial duties of any occupation to which the [**Covered Person**] [**Insured**] is suited by education, training, or experience[; or
2. with respect to a respect to a **Spouse**[/**Domestic Partner**] who is unemployed, his or her ability to engage in the normal and customary activities of a person of like age and gender in good health].

Terminal Injury or Terminally Injured means the **Covered Injury** suffered by the [**Covered Person**][**Insured**] bodily injury which resulted in the injured person having a life expectancy of [9] months or less.

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

[60] The range will be 60 - 70.

[\$3,000 and a maximum of \$100,000]. The range will be \$500 and a maximum amount of \$500,000. [30%] the range will be 10% - 100%.

This will be in or out.

This will be in or out. If in, [and Dismemberment] will be in or out

This will be in or out. If in: [/**Domestic Partner**] will be in or out

[9] The range will be 6 - 12 months.

[not] will be in or out.

ACCIDENT MEDICAL EXPENSE INDEMNITY BENEFIT - U-GMC-177-A CW (09/11)

<p>If [a Covered Person][an Insured] suffers a Covered Injury resulting in a Covered Loss under this Policy, We will pay the following benefits as applicable per [Covered Person][Insured] for each Covered Accident. The Covered Injury must be independent of Sickness or the medical or surgical treatment of Sickness, or of any cause other than a Covered Accident. A Covered Loss must also occur while coverage is in force.</p>	
<p>[Emergency Room Treatment We will pay [\$500] once per [48] hour period and once per Covered Accident, per [Covered Person][Insured] when that [Covered Person][Insured] receives emergency room treatment for Injuries sustained in a Covered Accident. This benefit is for treatment by a Physician or treatment received in a Hospital emergency room. Treatment must be received within [48] hours of the Accident for benefits to be payable.]</p>	<p>This will be in or out. If in: [\$500] the range will be \$25 - \$5,000; [48] the range will be 12 – 96;</p> <p>[48] the range will be 12 – 96.</p>
<p>[X-Rays Related to an Accident We will pay [\$500] once per Covered Accident, per [Covered Person][Insured] when a [Covered Person][Insured] requires an X-ray while receiving emergency room treatment in a Hospital for Injuries sustained in a Covered Accident. This benefit is not for X-rays received in a Physician's office. [The X-Ray Benefit is not for exams listed in the Diagnostic Testing & Exams Benefit.]]</p>	<p>This will be in or out. If in: [\$500] The range will be \$25 - \$1,000;</p> <p>This will be in or out.</p>
<p>[Emergency Room Follow Up Treatment We will pay [\$500] for one treatment per day, up to a maximum of [3] treatments per Covered Accident for each [Covered Person][Insured] when that [Covered Person][Insured] receives emergency room treatment for Injuries sustained in a Covered Accident and later requires additional treatment in addition to the original emergency room treatment administered in the first [48] hours following the Covered Accident. The emergency room follow up treatment must begin within [30] days of the Covered Accident or discharge from the Hospital, the Hospital Confinement which must be related to the same Covered Accident for which the subsequent treatment is being sought. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an outpatient basis. This benefit is not payable for days wherein additional emergency room treatment benefits are payable.]</p>	<p>This will be in or out. If in: [\$500] the range will be \$25 - \$1,000; [3] the range will be 2 – 6;</p> <p>[48] the range will be 12 – 96;</p> <p>[30] the range will be 10 – 90.</p>
<p>[Accident Hospitalization We will pay [\$500] once per period of Hospital Confinement or [\$500] once when a [Covered Person][Insured] is admitted directly to an Intensive Care Unit [2] time(s) per calendar year per [Covered Person][Insured] when that [Covered Person][Insured] is admitted for a Hospital Confinement of at least [18]</p>	<p>This will be in or out. If in: [\$500] the range will be \$500 - \$10,000; [\$500] the range will be \$500 - \$10,000;</p> <p>[2] the range will be 1 – 10;</p> <p>[18] the range will be 12 – 24;</p>

hours for treatment of **Injuries** sustained in a **Covered Accident** or if [a **Covered Person**][an **Insured**] is admitted directly to an **Intensive Care Unit** of a **Hospital** for treatment of **Injuries** sustained in a **Covered Accident. Hospital Confinements** must start within [60] days of the **Accident.**]

[Specific Principal Sum Accidental Injuries
We will pay [\$500] for the following **Covered Injuries**:

[1. Dislocation Benefit

Dislocation (reduced under general anesthesia)
We will pay for no more than [2] **Dislocations** per **Covered Accident** per [Covered Person][Insured].
 Benefits are payable for each **Dislocation** for each joint but for only the first **Dislocation** of a joint.

Benefit:

Joint Area	Open Reduction	Closed Reduction
A. - J.	[\$2,500]	[\$500]

If a **Dislocation** is reduced with local anesthesia, or no anesthesia by a **Physician** or a Physician Assistant, **We** will pay [50%] of the amount shown for the closed **Reduction Dislocation.**]

[2. Burn Benefit

For burns arising out of a **Covered Accident** and treated by a **Physician** within [48] hours after that **Covered Accident, We** will pay the following:

Benefit:

Body Surface Area	2 nd Degree	3 rd degree
A. Less than 50 sq. cm.	[2,500]	[\$5,000]
B. > than 100 but < 150 sq. cm	[2,500]	[\$5,000]
C. > than 150 but < 200 sq. cm	[2,500]	[\$5,000]
D. > than 200 but < 250 sq. cm	[2,500]	[\$5,000]
E. > than 250 but < 300 sq. cm	[2,500]	[\$5,000]
F. > than 300 sq cm	[2,500]	[\$5,000]

[3. Skin Grafts

If [a **Covered Person**][an **Insured**] receives up to [5] skin graft(s) for a burn from a **Covered Accident, We** will pay a total of [75%] of the Burns Benefit amount **We** paid for the burn involved in addition to the amount paid for the Burn Benefit.]

[4. Eye Injuries

If [a **Covered Person**][an **Insured**] sustains an **Injury** to an eye as a result of a **Covered Accident, We** will pay the following:
 a. Surgical repair [\$1,000]
 b. Removal of foreign body by a **Physician** [\$250].]

[5. Lacerations

If [a **Covered Person**][an **Insured**] sustains a

[60] the range will be 10 – 90

This will be in or out. If in:
 [\$500] the range will be \$25 - \$10,000

This will be in or out. If in:

[2] the range will be [1 – 10]

The ranges will be as follows:

Joint Area	Open Reduction	Closed Reduction
A. – J.	\$50 - 5,000	\$25 -1,500

[50%] the range will be 25% – 100%

This will be in or out. If in:
 [48] the range will be 12 – 96

The ranges will be as follows:

Body Surface Area	2 nd Degree	3 rd degree
A. Less than 50 sq. cm.	\$25-\$5,000	\$100-\$10,000
B. > than 100 but < 150 sq. cm	\$25-\$5,000	\$100-\$10,000
C. > than 150 but < 200 sq. cm	\$25-\$5,000	\$100-\$10,000
D. > than 200 but < 250 sq. cm	\$25-\$5,000	\$100-\$10,000
E. > than 250 but < 300 sq. cm	\$25-\$5,000	\$100-\$10,000
F. > than 300 sq cm	\$25-\$5,000	\$100-\$10,000

This will be in or out. If in:
 [5] the range will be 1 -10

[75%] the range will be 10% - 150%

This will be in or out. If in:

[\$1,000] the range will be \$25 – 2,500

[\$250] the range will be \$25 - 500

This will be in or out. If in:

laceration as a result of a **Covered Accident**, provided the laceration is repaired within [48] hours after the **Covered Accident** and repaired under the attendance of a **Physician**, **We** will pay the following:

Benefit:

Laceration	Benefit Amount
A. Laceration(s) not requiring . . .	[\$500]
B. Laceration(s) less than 5 cm. . . .	[\$500]
C. Lacerations at least 5 cm. . . .	[\$500]
D. Lacerations over 15 cm	[\$500]

[6. Fractures

We will pay for no more than [5] **Fractures** per **Covered Accident**, per **[Covered Person][Insured]**. In the event of multiple fractures (more than [3]) sustained by the same **[Covered Person][Insured]**, **We** will pay for the largest **Fracture** amount. However, **We** will pay [50%] of the benefit amount shown for the closed **Reduction** for **Chip Fractures** and other **Fractures** not reduced by Open or Closed **Reduction**.

Benefit:

Fracture Area	Open Reduction	Closed Reduction
A. – Q.	[\$100]	[\$100]
R. Finger	[\$100]	[\$100]
S. Coccyx	[\$100]	[\$100]
T. Toe	[\$100]	[\$100]
U. Vertebral	[\$100]	[\$100]
V. Skull		
i. Depressed	[\$100]	[\$00]
ii. Simple	[\$100]	[\$100]

[7. Concussion:

If [a **Covered Person**][an **Insured**] sustains a concussion as a result of a **Covered Accident**, **We** will pay [\$100] for each concussion for each **[Covered Person][Insured]**.

[8. Emergency Dental Procedure:

If the **[Covered Person][Insured]** sustains a **Covered Injury** as a result of a **Covered Accident** requiring emergency dental work, **We** will pay the following benefits:

- a. Broken tooth repaired with crown [\$75]
- b. Broken tooth resulting in extraction [\$75]

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. **We** will pay for no more than [2] Emergency Dental Procedure benefit(s) per **Covered Accident**, per **[Covered Person][Insured]**.

[9. Specified Surgical Procedures Arising from a Covered Accident:

If [a **Covered Person**][an **Insured**] sustains a **Covered**

[48] the range will be 12 - 96

The ranges will be as follows:

Laceration	Benefit amount
A. Laceration(s) not requiring . . .	\$25 - \$1,000
B. Laceration(s) less than 5 cm. . . .	\$25 - \$1,500
C. Lacerations at least 5 cm. . . .	\$25 - \$2,500
D. Lacerations over 15 cm	\$25 - \$5,000

This will be in or out. If in:

[5] the range will be 1 -10

[3] the range will be 2 – 10

[50%] the range will be 10% -100%

The ranges will be as follows:

Fracture Area	Open Reduction	Closed Reduction
A. – Q.	\$100 - \$25,000	\$100 - \$15,000
R. Finger	\$100 - \$5,000	\$100 - \$2,500
S. Coccyx	\$100 - \$25,000	\$100 - \$15,000
T. Toe	\$100 - \$5,000	\$100 - \$2,500
U. Vertebral	\$100 - \$25,000	\$100 - \$15,000
V. Skull		
i. Depressed	\$100 - \$25,000	\$100 - \$15,000
ii. Simple	\$100 - \$25,000	\$100 - \$15,000

This will be in or out. If in:

[\$100] the range will be \$50 – 1,500

This will be in or out. If in:

- a. [\$75] the range will be \$75 – 1,500
- b. [\$75] the range will be \$25 – 1,500

[2] the range will be 1 – 5.

This will be in or out. If in:

Injury as a result of a **Covered Accident** and one of the specified surgical procedures is required, such surgical procedure must be performed within [one (1)] year(s) of the **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure.

Benefit:

Surgical Procedure	Benefit Amount
A. Arthroscopy without surgical repair	[\$25]
B. Open abdominal	[\$25]
C. Cranial	[\$25]
D. Hernia	[\$25]
E. Thoracic surgery	[\$25]
F Repair of:	[\$25]
i. Tendons and/or ligaments	
ii. Torn rotator cuffs	
iii. Ruptured discs	
iv. Torn knee cartilages]

[10. Non-Specified Surgical Procedures Arising from a Covered Accident:

If [a **Covered Person**][an **Insured**] sustains a **Covered Injury** as a result of a **Covered Accident** and a non-specified surgical procedure is required, such surgical procedure must be performed within [one (1)] year of **Covered Accident**. [Two or more surgical procedures performed through the same incision will be considered one surgical procedure.] In the event of multiple procedures, **We** will pay for the most expensive procedure. **We** will pay for the following:

a. Miscellaneous surgery with general anesthesia
[\$2,500]

b. Other miscellaneous surgery with conscious sedation
[\$2,500]

[Diagnostic Testing & Exams Benefit

We will pay [\$2,500] [5] time(s) per calendar year, per **[Covered Person]****[Insured]** when a **[Covered Person]****[Insured]** requires one of the following exams for **Injuries** sustained in **Covered Accident** and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a Hospital or a Physician's office. [Exams listed in the Diagnostic Testing & Exams Benefit are not covered under the X-Ray Benefit.]

[Pain Management

We will pay [\$2,500] no more than [5] time(s) per **Covered Accident**, per **[Covered Person]****[Insured]** when the **[Covered Person]****[Insured]** is prescribed,

[one (1)] the range will be 1 - 3.
This will be in or out.

The ranges will be as follows:
[\$25] the range will be \$25 - \$10,000
[\$25] the range will be \$25 - \$10,000

This will be in or out. If in:

[one (1)] the range will be 1 - 3
This will be in or out.

[\$2,500] the range will be \$25 – \$2,500

[\$2,500] the range will be \$25 – \$2,500

This will be in or out. If in:
[\$2,500] the range will be \$25 – \$5,000
[5] the range will be 1 – 10

This will be in or out.

This will be in or out. If in:
[\$2,500] the range will be \$25 – \$5,000
[5] the range will be 1 – 10

receives, and incurs a charge for an epidural or other similar treatment administered for pain management in a **Hospital** or a **Physician's** office for **Injuries** sustained in a **Covered Accident**. This benefit is not for an epidural or other similar treatment administered during a surgical procedure [or for pain management associated with pregnancy].]

[Physical Therapy and Rehabilitation
We will pay [\$25] per treatment for [2] treatment(s) per day, up to a maximum of [5] treatment(s) per **Covered Accident**, per [**Covered Person**][**Insured**] when the [**Covered Person**][**Insured**] receives emergency treatment for **Injuries** sustained in a **Covered Accident** and later a **Physician** advises the [**Covered Person**][**Insured**] to seek treatment from a licensed **Physical Therapist**. Physical therapy must be for **Injuries** sustained in a **Covered Accident** and must start within [30] days of the **Covered Accident** or discharge from the **Hospital**. The treatment must take place within [6] month(s) after the **Covered Accident**. [The Physical Therapy Benefit is not payable on the same day that the Subsequent Emergency Room Treatment Benefit is paid.]]

[Durable Medical Equipment and Prosthetic Appliance
We will pay [\$5,000] once per **Covered Accident**, per [**Covered Person**][**Insured**] when [a **Covered Person**][an **Insured**] receives **Durable Medical Equipment**, prescribed by a **Physician**, as an aid in personal locomotion for **Injuries** sustained in a **Covered Accident**. Benefits are for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches. **We** will pay [\$5,000] once per **Covered Accident** per [**Covered Person**][**Insured**] when [a **Covered Person**][an **Insured**] requires use of a **Prosthetic Appliance** as a result of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to provide a benefit for the repair or replacement of **Prosthetic Appliance** already prescribed for the [**Covered Person**][**Insured**], hearing aids, wigs, or dental aids, including false teeth.]

[Blood, Plasma, and or Platelets
We will pay [\$2,500] once per **Covered Accident** per [**Covered Person**][**Insured**] when that [**Covered Person**][**Insured**] receives blood, plasma, and/or platelets for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is not intended to pay for immunoglobulins or other similar treatments.]

[Ambulance
We will pay [\$500] when [a **Covered Person**][an **Insured**] requires ambulance transportation and [\$5,000] when that [**Covered Person**][**Insured**] requires air ambulance transportation to a **Hospital** for **Injuries**

This will be in or out.

This will be in or out. If in:
[\$25] the range will be \$25 - \$500
[2] the range will be 1 - 2.
[5] the range will be 1 – 10

[30] the range will be 10 – 90

[6] the range will be 1 – 12
This will be in or out.

This will be in or out. If in:
[\$5,000] the range will be \$25 – \$10,000

[\$5,000] the range will be \$25 – \$10,000

This will be in or out. If in:
[\$2,500] the range will be \$25 – \$5,000

This will be in or out. If in:
[\$500] the range will be \$25 – \$1,000
[\$5,000] the range will be \$25 – \$10,000

sustained in a **Covered Accident**. Air Ambulance services must take place within [48] hours of the **Covered Accident**. Ambulance transportation must be within [48] hours of the **Covered Accident**. A licensed professional ambulance company must provide the ambulance service. A licensed professional air ambulance company must provide the air ambulance service.]

[Transportation

We will pay [\$25] per round trip, up to three round trips per calendar year, per **[Covered Person][Insured]** per round trip to a **Hospital** when a **[Covered Person][Insured]** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**. This benefit may also be used; if a covered **Dependent Child** requires **Hospitalization** or **Hospital Confinement** for medical treatment due to an **Injury** sustained in a **Covered Accident**, if commercial travel is necessary and such **Dependent Child** is accompanied by a person **Related** to the **[Covered Person][Insured]**. This benefit is not for transportation to any **Hospital** located within a [50]-mile radius from the site of the **Accident** or the residence of the **[Covered Person][Insured]**. The local attending **Physician** must prescribe the treatment requiring **Hospitalization** or **Hospital Confinement**, and the treatment must not be available locally. This benefit is not for transportation by ambulance or air ambulance to the **Hospital**.]

[Accommodations During **Hospital Confinement**

We will pay [\$50] per night, limited to one motel/hotel room per night, up to [5] days per **Covered Accident** for one motel/hotel room for a member of the immediate family who accompanies a **[Covered Person][Insured]** who is admitted for **Hospitalization** or **Hospital Confinement** for the treatment of **Injuries** sustained in a **Covered Accident**. This benefit is only during the same period of time the injured **[Covered Person][Insured]** is confined to the **Hospital**. The **Hospital** and motel/hotel must be more than [50] miles from the residence of the **[Covered Person][Insured]**.]

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

Ambulance means any publicly or privately owned surface, water or air vehicle, including a helicopter, that is specifically designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded. Ambulance does not include a surface, water or air vehicle that is owned and operated to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport.]

Dislocation means a completely separated joint due to

[48] the range will be 12 – 96
[48] the range will be 12 – 96

This will be in or out. If in:
[25] the range will be \$25 - \$1,000

[50] the range will be 5 - 100

This will be in or out. If in:
[\$50] the range will be \$25 – \$1,000
[5] the range will be 5 - 30

[50] the range will be 5 – 100

This will be in or out.

an **Injury**. The **Dislocation** must be diagnosed by a **Physician** [within 72 hours] after the date of the **Injury** and require correction by a **Physician**.

Fracture means a break in a bone due to an **Injury** and that can be seen by X-ray or other similar diagnostic exam. The **Fracture** must be diagnosed by a **Physician** [within 14 days after the date of the **Covered Injury**] and require correction by a **Physician**.

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

[within 72 hours] will be in or out.

[within 14 days after the date of the **Covered Injury**] will be in or out.

[not] will be in or out.

COMPLICATIONS OF PREGNANCY BENEFIT - U-GMC-178-A CW (09/11)

<p>If a Covered Person suffers a Covered Complications of Pregnancy, [other than a Non-elective Cesarean Section,] resulting from a Covered Accident, We will pay the [coinsurance percentage of the] [Usual and Customary] expenses for Medically Necessary Covered Medical Service(s) incurred up to the Maximum Amount as shown on the Schedule. [The Maximum Amount is the amount payable per calendar year for all Covered Complications of Pregnancy payable under the Policy.] This benefit is payable only for such Covered Charges incurred [after the Deductible, as shown on the Schedule, has been met and] on or after the date the Covered Person suffers the Covered Complications. [Complications of Pregnancy Benefits are in excess of all other valid and collectible Insurance.]</p>	<p>This will be in or out.</p> <p>This will be in or out. If in, the coinsurance percentage will range from 5% to 50%. [Usual and Customary] will be in or out. The Maximum Amount will be in or out. If in, the amount will range from \$100 to \$100,000.</p> <p>This will be in or out. The Deductible will range from \$0 to \$10,000. This will be in or out.</p>
<p>[If the Covered Complications of Pregnancy are a Medically Necessary Non-elective Cesarean Section, after the applicable Deductible has been met and on or after the date the Non-elective Cesarean Section is performed, benefits are payable on the same basis as any other Covered Complication for Covered Charges incurred, up to the Maximum Amount shown in the Benefit Schedule.]</p>	<p>This will be in or out. If in:</p> <p>The Maximum Amount will range from \$100 to 10,000.</p>
<p>[Additional Benefit If the Covered Person's coverage terminates under this benefit solely due to the birth of a child, an Additional Benefit will be provided for [six (6)] [weeks][months] from the date of termination for [Covered Complications] [and] [post-partum depression] resulting solely from that Covered Accident. This benefit is payable only for such Covered Charges incurred [after the applicable Deductible, as shown on the Benefit Schedule, has been met and] on or after the date the Covered Person suffers the Covered Complications, subject to the Additional Benefit Maximum Amount shown on the Schedule. [The overall Maximum Amount for Complications of Pregnancy payable per calendar year will be reduced by the amount paid under this Additional Benefit.] Benefits provided under this rider are subject to all other terms and limitations of the Policy.]</p>	<p>This will be in or out. If in:</p> <p>[6] the number of weeks or months will be inserted, will range from 4 weeks to 6 months; [weeks] will be in or out [months] will be in or out. [Covered Complications] will be in or out. [and] will be in or out. [post-partum depression] will be in or out. [after the applicable Deductible, as shown on the Benefit Schedule, has been met and] will be in or out. This will be in or out. If in, the Additional Benefit Maximum Amount will range from \$100 to \$100,000.</p>
<p>Covered Complications of Pregnancy (Covered Complications) means any of the following conditions requiring [treatment by a Physician] [Hospital Confinement] [when the pregnancy is not terminated] whose diagnoses... 4. missed abortion; [and] 5. similar medical and surgical conditions of comparable severity;[and] 6. [Non-Elective Cesarean Section;] [and]</p>	<p>[treatment by a Physician] [Hospital Confinement] will be in or out. [when the pregnancy is not terminated] will be in or out. [and] will be in or out.</p> <p>[and] will be in or out. [Non-Elective Cesarean Section]; [and] will be in or out.</p>
<p>Covered Complications of Pregnancy do not include false labor, occasional spotting, [Physician-prescribed rest during the period of pregnancy,] morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated</p>	<p>This will be in or out.</p>

<p>with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.</p>	
<p>[Deductible] means the amount of Usual and Customary expenses for Medically Necessary treatment of [Covered Complications][Non-elective Cesarean Sections] that must be incurred by the [Covered Person][Insured] before [Covered Complications][Non-elective Cesarean Section] benefits become payable. The amount of the Deductible is shown on the Schedule. Covered Complications benefits are not payable for charges applied to the Deductible.]</p>	<p>This will be in or out. If in: [Covered Complications] [Non-elective Cesarean Sections] will be in or out.</p> <p>[Covered Complications] [Non-elective Cesarean Sections] will be in or out. the Deductible will range from \$0 to 10,000.</p>
<p>Hospital Confined (Hospital confinement) means admission to a Hospital as an inpatient [for at least 24 consecutive hours] by a Physician for a Covered Complication.</p>	
<p>[Non-Elective Cesarean Section] means an unscheduled cesarean section due to an emergency which puts the life and health of the Covered Person or fetus in jeopardy.]</p>	<p>This will be in or out.</p>
<p>[Pre-existing Condition] means a condition for which 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 Complication [unless the condition for which the prescribed medication is taken remains controlled without any change in the required prescription].]</p>	<p>This will be in or out. If in:</p> <p>The range will be 1 – 24. This will be in or out.</p>
<p>[Usual and Customary Expense(s) (Covered Charges)] means an amount(s) that: ...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] (3) does not include charges that would not have been made if no insurance existed [and (4) 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>This will be in or out. If in:</p> <p>This will be in or out. [and] will be in or out.</p> <p>This will be in or out. If in, [seventy-five percent (75%)] the range will be 25% – 100%.</p>
<p>Termination of Covered Person's Insurance. [Insured. Insurance terminates at the end of the [month][date] for which premium has been paid and during which any of the following occurs:</p> <ol style="list-style-type: none"> 1. the Policy is terminated; 2. the Insured ceases to be eligible for insurance; 3. the Insured fails to pay the required premium, if the Insured is so required; 4. the birth of a child as a result of a Covered Accident; 5. [the Insured reaches age [70]]; 6. [the Insured retires].] 	<p>This will be in or out. If in: [month][date] The termination will be stated in terms or months or dates.</p> <p>This will be in or out. If in, the range will be 65 – 85. This will be in or out.</p>
<p>[Insured. Insurance automatically terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. the date the Policy is terminated; 2. the date the Insured ceases to be eligible for 	<p>This will be in or out. If in:</p>

<p>insurance;</p> <ol style="list-style-type: none"> 3. the expiration date of the period for which required premium has been paid for such Insured; 4. the date the Insured fails to pay the required premium, if the Insured is so required; 5. the date of the birth of a child as a result of a Covered Accident; 6. [the date the Insured reaches age [70]]; 7. [the date the Insured retires.]] <p>[If an Insured has received approval for a benefits eligible leave of absence, layoff or sabbatical from the Policyholder in accordance with the Policyholder's written Policy, his or her insurance under this Policy will continue, provided the required premiums are paid. This extension of coverage is subject to all of the termination provisions of this Policy with the exception of number 2. above.]</p> <p>[Covered Person other than the Insured. Insurance terminates on the earliest of:</p> <ol style="list-style-type: none"> 1. the date the insurance of the Insured terminates; 2. the first premium due date after the person no longer qualifies as a Covered Person; 3. the date of the birth of a child to the Covered Person as a result of a Covered Accident. 4. [for the Covered Spouse[/Domestic Partner], the date the Covered Spouse[/Domestic Partner] reaches age [70].]] <p>EXCLUSIONS: For purposes of this rider only, in addition to the General Exclusions stated in Section IV of the Policy, We will not provide coverage under this rider for any of the following:</p> <p>Personal comfort or convenience items, such as but not limited to Hospital telephone charges, television rental, or guest meals while confined in a Hospital [or for items taken away or home from the Hospital, [including but not limited to crutches, wheel chairs and walkers] [except Durable Medical Equipment]].]</p> <p>.Charges that are payable under automobile medical benefits [in excess of [\$5,000]].]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy/Certificate.</p>	<p>This will be in or out. If in, the range will be 65 - 85. This will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. If in:</p> <p>This will be in or out. If in: [Domestic Partner] will be in or out. [70] the range will be 65 - 85.</p> <p>Any combination of exclusions 1 through 31 may be in or out.</p> <p>If this exclusion is included: [or for items taken away...] will be in or out. If in: [including but not...] will be in or out. [except...] will be in or out.</p> <p>If this exclusion is included: [in excess...] will be in or out. If in, the range will be \$500 - \$10,000]</p> <p>[not] will be in or out.</p>
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~~Blank~~ Administrative Change Endorsement



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

[This endorsement will be used to make the following types of administrative changes to the **Policy/Certificate**, ~~which are administrative in nature at the Policyholder's request:~~

1. Policyholder's Name or Address;
- ~~(1) changes to the Schedule;~~ 2. ~~(2) A~~ addition or deletion of a subsidiary or affiliates of the **Policyholder**;
3. ~~(3) C~~ changes to the class(es) of ~~eligible covered~~ persons;
4. ~~(4) Addition or deletion of Coverage(s) annual audit requirement; and (5) other administrative changes to the~~
Policy/Certificate
5. Increase or decrease in Coverage Amount(s);
6. Addition or deletion of Benefit Riders;
7. Increase or decrease in Benefit Amount(s); or
8. Renewal of the Policy.]

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

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

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