

SERFF Tracking Number: WESA-127087904 State: Arkansas  
Filing Company: Arch Insurance Company State Tracking Number: 48284  
Company Tracking Number: ARCH-11-071  
TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
Product Name: Arch Volunteer FF Blanket Accident  
Project Name/Number: Arch Volunteer FF Blanket Accident/ARCH-11-071

## Filing at a Glance

Company: Arch Insurance Company

Product Name: Arch Volunteer FF Blanket Accident SERFF Tr Num: WESA-127087904 State: Arkansas

Accident

TOI: H04 Health - Blanket Accident/Sickness SERFF Status: Closed-Approved-Closed State Tr Num: 48284

Sub-TOI: H04.000 Health - Blanket Accident/Sickness Co Tr Num: ARCH-11-071 State Status: Approved-Closed

Filing Type: Form

Authors: Darcy Lebau, Carolyn Smart

Reviewer(s): Rosalind Minor

Disposition Date: 03/22/2011

Date Submitted: 03/18/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Arch Volunteer FF Blanket Accident

Project Number: ARCH-11-071

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Blanket

Filing Status Changed: 03/22/2011

State Status Changed: 03/22/2011

Created By: Darcy Lebau

Corresponding Filing Tracking Number: ARCH-11-071

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

March 18, 2011 via SERFF

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Darcy Lebau

The Honorable Julie Benafield Bowman

Commissioner of Insurance

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Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
Attention: Life & Health Division

RE: Arch Insurance Company  
Filing Designation # ARCH-11-071  
FEIN#: 43-0990710  
NAIC#: 1279 11150

Blanket Accident Product Forms  
Blanket Insurance Policy Form # 05 VF0001 00 02 11  
Blanket Insurance Certificate Form # 05 VF0002 00 03 11  
Endorsement Form # 05 VF0003 00 03 11  
Accident Insurance Application Form # 00 VF0004 00 03 11

Honorable Commissioner Bowman:

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

The Blanket Accident Policy, Form #05 VF0001 00 02 11, provides accident benefits to eligible blanket groups comprising of volunteer firefighters and emergency services personnel only. Arch files these forms as variable, offering accidental death and dismemberment benefits and additional benefits triggered by an accident resulting from a covered injury either separately or in combination on a non-contributory basis.

As the policyholder will select the benefits for its group, only the benefits and dollar amounts will vary. Variable data is bracketed and may vary on a case basis. Please see the enclosed Statement of Variability for Arch's explanation of how this data may vary. This product will be marketed by licensed producers and brokers to eligible groups.

In accordance with Arkansas' filing requirements, enclosed please find:

- Readability Certification
- Letter of Authorization
- Forms
- Statement of Variability
- Certificate of Compliance
- Rule 49 Appendix A
- Consumer Information Notice

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

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Respectfully,  
 Darcy Lebau  
 Darcy Lebau

## Company and Contact

### Filing Contact Information

Darcy LeBau, darcy@westmontlaw.com  
 25 Chestnut Street, Suite 105 856-216-0220 [Phone]  
 Haddonfield, NJ 08033

### Filing Company Information

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

Arch Insurance Company	CoCode: 11150	State of Domicile: Missouri
300 Plaza Three	Group Code: 1279	Company Type: Property and Casualty
Jersey City, NJ 07311-1107	Group Name:	State ID Number:
(201) 743-4000 ext. [Phone]	FEIN Number: 43-0990710	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation: Missouri, Arch Insurance Company's domiciliary state, charges \$50 per filing.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arch Insurance Company	\$50.00	03/18/2011	45754423
Arch Insurance Company	\$150.00	03/21/2011	45814389

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/22/2011	03/22/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	03/21/2011	03/21/2011	Darcy Lebau	03/21/2011	03/21/2011

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## Disposition

Disposition Date: 03/22/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	No
<b>Supporting Document</b>	Application	Approved-Closed	No
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	No
<b>Supporting Document</b>	Letter of Authorization	Approved-Closed	No
<b>Supporting Document</b>	Statement of Variability	Approved-Closed	No
<b>Supporting Document</b>	Cover Letter	Approved-Closed	No
<b>Form</b>	Blanket Insurance Policy	Approved-Closed	No
<b>Form</b>	Blanket Insurance Certificate	Approved-Closed	No
<b>Form</b>	Accident Insurance Application	Approved-Closed	No
<b>Form</b>	Endorsement	Approved-Closed	No

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 03/21/2011

Submitted Date 03/21/2011

Respond By Date

Dear Darcy LeBau,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Blanket Insurance Policy, 05 VF0001 00 02 11 (Form)
- Blanket Insurance Certificate, 05 VF0002 00 03 11 (Form)
- Accident Insurance Application, 00 VF0004 00 03 11 (Form)
- Endorsement, 05 VF0003 00 03 11 (Form)

### Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$200.00. Please submit an additional \$150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 03/21/2011  
Submitted Date 03/21/2011

Dear Rosalind Minor,

### Comments:

Good afternoon.

## Response 1

Comments: I have submitted the additional filing fee per your request.

### Related Objection 1

Applies To:

- Blanket Insurance Policy, 05 VF0001 00 02 11 (Form)
- Blanket Insurance Certificate, 05 VF0002 00 03 11 (Form)
- Accident Insurance Application, 00 VF0004 00 03 11 (Form)
- Endorsement, 05 VF0003 00 03 11 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$200.00. Please submit an additional \$150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

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No Rate/Rule Schedule items changed.

Thank you for your time and attention to this filing.

Respectfully,

Darcy Lebau

Sincerely,

Carolyn Smart, Darcy Lebau

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## Form Schedule

### Lead Form Number: 05 VF0001 00 02 11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 03/22/2011	05 VF0001 00 02 11	Policy/Cont ract/Fratern al Certificate	Blanket Insurance Policy	Initial		47.800	ESIP Countrywide Policy.pdf
Approved- Closed 03/22/2011	05 VF0002 00 03 11	Certificate Certificate	Blanket Insurance Certificate	Initial		47.800	ESIP Countrywide Cert.pdf
Approved- Closed 03/22/2011	00 VF0004 00 03 11	Application/ Enrollment Form	Accident Insurance Application	Initial		47.800	ESIP Application.pdf
Approved- Closed 03/22/2011	05 VF0003 00 03 11	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Endorsement	Initial		47.800	ESIP Endorsement. pdf



**ARCH INSURANCE COMPANY**  
(A Missouri Corporation)

Home Office Address:  
3100 Broadway, Suite 511  
Kansas City, MO 64111

Administrative Address:  
One Liberty Plaza, 53rd Floor  
New York, NY 10006  
Tel: (800) 817-3252

**BLANKET INSURANCE POLICY**

**POLICYHOLDER:** ABC

**POLICY NUMBER:** 12345

**POLICY EFFECTIVE DATE:** January 1, 2010

**POLICY ANNIVERSARY DATE:** January 1

**POLICY TERM:** January 1, 2010 – January, 2011

**STATE OF DELIVERY:** Connecticut

The Policy takes effect at 12:01 A.M. on the Policy Effective Date shown above. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. The Policy terminates at 12:01 A.M., on the last day of the Policy Term and unless the Policyholder and We agree to continue coverage under the Policy for an additional Policy Term. If coverage is continued for an additional Policy Term and the required premiums are paid on or before the Premium Due Date, We will issue a rider to identify the new Policy Term.

The Policy is governed by the laws of the state in which it is delivered.

IN WITNESS WHEREOF, Arch Insurance Company has caused this policy to be executed and attested.

A handwritten signature in cursive script, appearing to read "Martin J. Nilsen".

\_\_\_\_\_  
Martin J. Nilsen  
Secretary

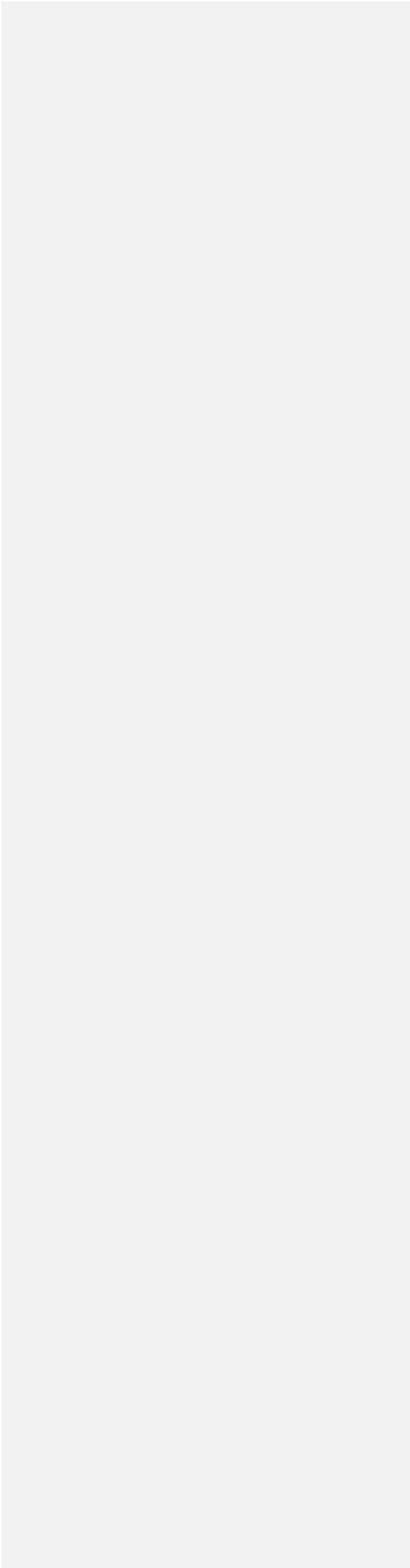
A handwritten signature in cursive script, appearing to read "Mark D. Lyons".

\_\_\_\_\_  
Mark D. Lyons  
President

**LIMITED BENEFITS: THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES DURING THE HAZARDS SHOWN IN THE SCHEDULE OF BENEFITS ONLY. PLEASE READ THE POLICY CAREFULLY.**

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**SECTION 1: SCHEDULE OF BENEFITS**

**POLICYHOLDER NAME:**

**POLICYHOLDER ADDRESS:**

**POLICY NUMBER:**

**POLICY EFFECTIVE DATE:**

**POLICY ANNIVERSARY DATE:**

**POLICY TERM:**

**PREMIUM DUE DATE:** Annually in advance on Anniversary Date

**CLASSES OF ELIGIBLE PERSONS:**

This Policy provides coverage for the following class(es) of Covered Person(s) only:

[For the Municipality stated as the Policyholder, coverage under this Policy is limited to the indicated Classes of Eligible Persons of {list applicable fire, emergency, rescue or ambulance department}.]

Class 1 Volunteers]

[Any officially designated member in good standing of the Policyholder, including 1) Volunteer members or volunteer members who receive nominal fees as retainers; 2) registered junior members; 3) any director, commissioner, trustee, board member, officer of the board, or holder of a similar position; 4) part time employees of the Policyholder with no more than 1,300 hours annually; and 5) any bystander deputized by an official of the Policyholder at the scene of an emergency to assist at the emergency, but only until the emergency ends. Eligibility does not include a paid employee of the Policyholder who works more than 1,300 hours annually for the Policyholder and who is acting within the scope of his or her employment.]

Class 2 Auxiliary]

[A member of the Policyholder's auxiliary organization by whatever name called and 1) any person while assisting the auxiliary organization if requested to do so by an officially designated member in good standing of the Policyholder or the Policyholder's auxiliary organization and 2) any person while assisting the Policyholder if requested to do so by an officially designated member in good standing of the Policyholder.]

Class 3 Career Personnel]

[A paid employee of the Policyholder who works more than 1,300 hours for the Policyholder and who is acting within the scope of his or her employment.]

**HOW BENEFITS ARE PAID**

If "**Primary**", **We** will pay covered medical expenses incurred by a Covered Person on a primary basis without regard to benefits that may be paid or payable under Workers' Compensation or any Other Valid and Collectible Insurance.]

If "**Excess**", **We** will not pay covered medical expenses incurred by a Covered Person that are paid or payable under Workers' Compensation or any Other Valid and Collectible Insurance.]

**ANNUAL PREMIUM: \$**

**SCHEDULE OF BENEFITS (continued)**

PART	BENEFIT	AMOUNT OF INSURANCE	CLASSES OF ELIGIBLE PERSONS		
			1	2	3
<b>I</b>	<b>Indemnity Benefits</b>				
	A. Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Illness Loss of Life Benefit	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Seat Belt Benefit	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Post Traumatic Stress Disorder Benefit – Per Person, Per Covered Activity	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>II</b>	<b>Permanent Physical Impairment Benefit – Injury Only</b>	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>III</b>	<b>Permanent Physical Impairment Benefit – Illness Only</b>	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IV</b>	<b>Weekly Disability Permanent Physical Impairment Benefit – Injury Only</b>	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>V</b>	<b>Cosmetic Burn Disfigurement Benefit – Injury Only</b>	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VI</b>	<b>Permanent Cardiac Impairment Benefit – Illness Only</b>	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VII</b>	<b>Medical Expense Benefit – Injury Only</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	A. Medical Expenses	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Additional for Plastic Surgery Expenses	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VIII</b>	<b>Medical Expense Benefit – Illness Only</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	A. Medical Expenses	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Preventative Inoculations	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IX</b>	<b>Weekly Disability Benefit – Injury Only</b>				
	A. Total Disability	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Partial Disability	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>X</b>	<b>Weekly Disability Benefit – Illness Only</b>				
	A. Total Disability	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Partial Disability	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XI</b>	<b>Family Expense Benefit – Injury or Illness</b>	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XII</b>	<b>Family Education Benefit – Injury or Illness</b>				
	A. Dependent Child	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Surviving Spouse or Domestic Partner	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Other	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XIII</b>	<b>Athletic and Special Events Benefit – Injury Only</b>				
	A. Medical Expense	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Total Disability	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XIV</b>	<b>HIV Benefit</b>				
	A. HIV Lump Sum	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. HIV Infection Prevention	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XV</b>	<b>Physical Assault Benefit – Injury Only</b>	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XVI</b>	<b>Day Care Expense Benefit – Injury or Illness (up to a maximum of 26 weeks)</b>	Household Maximum (per Day) \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XVII</b>	<b>Permanent Physical Impairment Education Benefit – Injury Only</b>	35% of Permanent Physical Impairment Benefit – Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XVIII</b>	<b>Residence and Vehicle Adaptation Expense Benefit</b>	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SCHEDULE OF BENEFITS (continued)**

PART	BENEFIT	AMOUNT OF INSURANCE	CLASSES OF ELIGIBLE PERSONS		
			1	2	3
XIX	Continuation of Coverage Benefit – Injury Only	Per Month \$ Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XX	Accidental Death and Dismemberment – Injury Only	24 Hour Coverage <input type="checkbox"/> Off-Duty Coverage <input type="checkbox"/>			
	A. Loss of Life	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Dismemberment Loss	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Loss of Life – Military Duty	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXI	Burial and Cremation Benefit	10% of Principal Sum – Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXII	Survivor Benefits				
	A. Child	10% of Principal Sum – Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Surviving Spouse or Domestic Partner	10% of Principal Sum – Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Elder	10% of Principal Sum – Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXIII	Transition Benefit	Maximum \$ Maximum Number of Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXIV	Critical/Traumatic Incident Stress Management Team	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXV	Emergency Medical Evacuation and Repatriation Benefit	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXVI	Repatriation Benefit	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXVII	Optional Benefits				
	A. Additional Weekly Disability Benefit – 1 <sup>st</sup> Week of Total Disability	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Weekly Hospital Indemnity Benefit	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Auxiliary Member Benefits – Injury Only				
	1. Indemnity Benefits	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Medical Expense	Maximum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Weekly Disability	Weekly Benefit \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Organized League Sports Benefit*				
	1. Accidental Death, Dismemberment, Loss of Sight, Speech, or Hearing	Principal Sum \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Medical Expense	Maximum \$ Deductible \$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Weekly Disability	Weekly Benefit \$ Waiting Period Maximum Number of Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	*Sports Teams Covered:				

## SECTION 2: DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**Accident** - means a sudden, unexpected and unintended event that results in Injury to the Covered Person.

**Athletic Games, Contests or Special Events** - means any athletic game, contest or special event that: (1) the Policyholder has organized, sanctioned or approved of; and (2) is not part of a regularly scheduled activity of an organized league, nor sponsored by an organized league. However, Athletic Games, Contests or Special Events does not include football (tackle, touch or flag), ice hockey, field hockey, lacrosse, soccer, wrestling, rugby or boxing.

**Average Weekly Wage** – means the Covered Person's average personal income per week based upon the greater of the following: 1) the amount shown for "wages, salaries, tips, etc." on the Covered Person's U.S. Individual Income Tax Return for the calendar year immediately preceding the year in which the loss occurred; 2) the wages or income earned by the Covered Person in the 12 months immediately preceding the loss; 3) the wages or income earned by the Covered Person in the 3 months preceding the loss; or 4) if self-employed, the amount shown as Business Income (Schedule C), Supplemental Income (Schedule E), and/or Farm Income (Schedule F), excluding rental income, investment income, or other passive income, on the Covered Person's U.S. Individual Income Tax Return for the calendar year immediately preceding the year in which the loss occurred.

**Cardiac Malfunction** – means a sudden and serious malfunction of the heart or circulatory system caused by and directly resulting from participation in a Covered Activity while coverage is in force under the Policy. Such malfunctions shall include those commonly diagnosed as myocardial infarction, cardiac arrest, coronary thrombosis and cerebral vascular accident (e.g. stroke or aneurysm.) Cardiac Malfunction does not include conditions such as hypertension or angina.

**Covered Activity** – means participation in, including travel directly to and from, any activity that is: (1) a normal duty of an Covered Person for the Policyholder; and (2) performed at the direction or with the knowledge of an officer of the Policyholder, or (3) at the scene of an emergency requiring immediate action not on behalf of the Policyholder. Such activity includes but is not limited to: (1) fire suppression or an emergency response; (2) rescue or emergency medical activity; (3) training exercise; (4) fund raising including athletic activities, however, covered athletic activities are limited to those performed for the sole purpose of fund-raising for the Policyholder; (5) a drill, parade, conference, convention, meeting, or dinner; or (6) a Firematic Event or Contest, or other competitive or non-competitive training school or program.

**Covered Loss(es)** - means an accidental death, dismemberment or other Injury or Illness covered under the Policy.

**Covered Person** – means an eligible person who is within the covered class(es) listed in the Policy and for whom the required premium is paid when due.

**Critical Incident Stress Management Team (CISMT)** – means a formally organized group of mental health professionals and peer support individuals trained to provide support services to emergency service personnel. Such support services include stress debriefing, defusing, demobilization, stress education, spousal support, one-on-one interviews, or on the scene support.

**Day Care Expense** - means the reasonable and customary cost of providing regular daily supervision or nursing services for a member of the Covered Person's Immediate Family if such family member is a child age 12 years or younger or such person is mentally or physically disabled or infirmed and would reasonably require such care. Day Care Expense does not include the cost of any care provided by a Covered Person or an Immediate Family Member, nor by any individual or organization that is not duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received.

**Deductible** - means the dollar amount of covered expenses that must be incurred by the Covered Person as an out-of-pocket expense on a per Accident basis before Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Policy.

**Dependent Child** - means an unmarried child who is dependent upon the Covered Person as of the date of the Covered Person's death for at least 50% of his or her support and maintenance.

**Domestic Partner** - means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

**Firematic Events or Contests** - means practice or participation in an organized event intended to enhance the Covered Person's skills or emergency reaction times. These events include, but are not limited to, departmental or interdepartmental: (1) apparatus pumping contests; (2) battle of the barrel; (3) antique pumping; (4) hose rolling contests; (5) equipment donning contests; (6) bucket brigades; (7) ladder climbs; (8) tug of war contests; and (9) apparatus operation rodeos.

**Home Health Care** - means those nursing and other home health care services provided to a Covered Person in his or her place of residence. Home Health Care must be: (1) performed by a Home Health Care Practitioner; (2) in lieu of confinement in a Hospital or nursing facility, and (3) pursuant to the orders of the attending Physician. Such attending Physician's orders must be written and include a plan of care which must be reviewed and approved by the Physician on an ongoing basis.

**Home Health Care Practitioner** - means a nurse, medical social worker, home health aide, physical therapist, or other medical practitioner. However, no provider will be considered a Home Health Care Practitioner unless such practitioner is: (1) duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received, and (2) not a Covered Person or an Immediate Family Member.

**Hospital** - means an institution that: (1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons, and is a duly licensed institution, operated lawfully in its area; (2) provides 24-hour nursing service by registered nurses on duty or call; (3) has a staff of one or more licensed Physicians available at all times; (4) provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; (5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and (6) is not a facility for the treatment of drug addiction, alcoholism, treatment of the aged.

We will not deny a claim for services rendered in a Hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability: (1) the Joint Commission of Accreditation of Hospitals; or (2) the American Osteopathic Association; or (3) the Commission on the Accreditation of Rehabilitative Facilities.

**Illness** - means any disease, illness, or infection caused by or resulting directly from the Covered Person's participation in a Covered Activity. Illness includes Cardiac Malfunction. Illness does not include Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or any AIDS related disease, illness, infection, or debility.

**Immediate Family Member** - means the Covered Person's parent, grandparent, spouse, child(ren) (includes legally adopted), step child(ren), brother, sister, grandchild(ren), in-laws or any person living at the time of loss in the Covered Person's household.

**Injury** - means accidental bodily Injury sustained by the Covered Person: (1) during and resulting from a Covered Person's participation in a specific Covered Activity while coverage under the Policy is in force as to the Covered Person; and (2) which directly (independent of Illness, disease, mental incapacity or

any other cause) causes a loss to the Covered Person; Injury does not include: (1) Illness; (2) Cardiac Malfunction; nor (3) Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or any AIDS-related disease, illness, infection, or debility.

**Institution of Higher Learning** - includes but is not limited to, any state university, private college, professional or trade school.

**Intoxication** - means the Covered Person is intoxicated by the use of alcohol or the illegal use of drugs as defined by the applicable state Motor Vehicle statutes in the state where the Injury occurred.

**Left Ventricular Ejection Fraction** - means a clinically used measure of the function of the left ventricle. The ejection fraction is the percentage of blood ejected from the left ventricle with each heart beat.

**Maximum Medical Improvement** - means the point where a Covered Person's condition will no longer improve by treatment or time.

**New York Heart Association (NYHA) Functional Classification** - means a four category classification system used to assess the stage or extent of heart failure. The system relates symptoms to everyday activities and the patient's quality of life. A summary of the four categories is as follows:

Class I No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or shortness of breath.

Class II Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or shortness of breath.

Class III Marked limitation of physical activity. Comfortable at rest, but less than ordinary physical activity results in fatigue, palpitation, or shortness of breath.

Class IV Unable to carry out any physical activity without discomfort. If any physical activity is undertaken, discomfort is increased.

**Other Valid and Collectible Insurance** - means any: 1) group plan, program, or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans or group employer or employee benefit programs; or (4) any no-fault automobile insurance plan or similar law. Other Valid and Collectible Insurance will not include benefits provided by the United States Social Security Act or any individual disability insurance plans.

**Partial Disability, Partially Disabled** - means a Covered Person's inability to do one or more, but not all, of the material and substantial duties of his or her Regular Occupation. The Covered Person must be under the regular care of a Physician during Partial Disability.

**Period of Eligibility** - means a period of time from the date the Covered Person receives notice from Us by certified mail of the right to claim a benefit under the Weekly Disability Permanent Physical Impairment Benefit to: (1) [90] days after receipt of notice from Us, or (2) [260] weeks from the date of the Injury that caused the Permanent Physical Impairment, whichever is sooner.

**Permanent Cardiac Impairment** - means a medical condition causing an abnormality of, partial loss of, or loss of function of the heart resulting in: 1) a Left Ventricular Ejection Fraction of [30%] or less; and 2) a New York Heart Association Functional Classification of II, III, or IV.

**Permanent Physical Impairment** - means a medical condition that is a physical or functional abnormality or loss, that remains after Maximum Medical Improvement has been achieved, and that is considered stable or non-progressive by the Physician at the time an evaluation is made.

**Physical Assault** - means a physical Injury as a result of a deliberate and offensive act directed towards the Covered Person that creates a substantial risk of death, or that causes death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ.

**Physician** - means a person who is a qualified doctor of medicine or dental practitioner. As such, he or she must be acting within the scope of his or her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his or her license or certificate. Physician includes a physician's assistant or nurse practitioner. Physician does not include the Covered Person, Immediate Family Member, a physical therapist, or an intern.

**Policy** - means the contract issued to the Policyholder named in the Policy application.

**Policy Term** - means the period of time a Policyholder group is covered by the Policy. The Policy Term is shown in the Schedule of Benefits.

**Policyholder** - means a [non-profit emergency service organization] [or Municipality] that elects coverage under the Policy and pays the required premium. Coverage under the Policy for a Policyholder group will become effective on the Policy Effective Date shown in the Schedule of Benefits, subject to the payment of the required premium.

**Post Traumatic Stress Disorder** - means (1) recurrent and intrusive distressing recollections of the traumatic event; (2) recurrent distressing dreams of the traumatic event; (3) suddenly acting or feeling the traumatic event is recurring; or (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event.

**Reasonable and Customary Expense** - means an expense that: (1) is charged for treatment, supplies or medical services medically necessary to treat the Covered Person's condition; (2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

**Regular Occupation** - means the full or part-time gainful employment of the Covered Person at the time of Injury or Illness. Should the Covered Person not be gainfully employed at the time of Injury or Illness, Regular Occupation means the Covered Person's normal lifestyle he could engage in at the time of Injury or Illness. Regular Occupation in no way relates to the Covered Person's duties or responsibilities as a volunteer for the Policyholder.

**Residence and Vehicle Adaptation Expenses** - means one-time expenses incurred by or paid on behalf of the Covered Person for (1) adaptation of the Covered Person's residence to make it accessible to and/or habitable by the Covered Person; and (2) adaptation of the Covered Person's vehicle to make it accessible to and/or drivable by the Covered Person. The adaptations must be (1) made by an individual experienced in such adaptations; and (2) in compliance with any applicable laws of or requirements for approval by local, state or federal government authorities.

**Schedule** - means the Schedule of Benefits which is part of this Policy, Certificate or summary of coverage.

**Sports Injury** - means accidental bodily Injury sustained during and directly resulting from an organized game or practice of a Sports Team, or while traveling directly to or from such game or practice that directly and independently causes a loss to the Covered Person. Sports Injury does not include: (1) Illness; (2) Cardiac Malfunction; nor (3) bodily Injury triggered by or related to any known or previously diagnosed pre-existing heart or circulatory condition.

**Sports Team** - means a team officially recognized, sponsored, authorized, or supervised by the Policyholder, provided that it is a part of, or competes under the sponsorship of, an established amateur athletic league, by whatever name called.

**Surviving Spouse** - means the legal spouse of the Covered Person as of the date of the Covered Person's death according to the laws of the state in which the Covered Person resides on the date of death.

**Total Disability, Totally Disabled** - means a Covered Person's inability to perform the material and substantial duties of his or her Regular Occupation. After 5 years from the date of Injury or Illness, Total Disability and Totally Disabled means the Covered Person's inability to perform the material and substantial duties of any occupation for which the Covered Person is reasonably suited based on education and experience. The Covered Person must be under the regular care of a Physician during Total Disability.

**We, Our, Us** - means the Insurance Company underwriting this insurance.

### **SECTION 3: ELIGIBILITY FOR INSURANCE**

If the Covered Person is in one of the Classes of Eligible Persons shown in the Schedule of Benefits, he or she is eligible to be insured on the Policy Effective Date. New eligible persons added from time to time to the Policyholder group will automatically be covered under the Policy if premium is paid for such persons.

A Covered Person's Dependent is eligible on the date:

1. the Covered Person is eligible, if the Covered Person has Dependents on that date; or
2. the date the person becomes a Dependent, if later.

If the Covered Person is in a Class of Eligible Persons and is also eligible as a Dependent, he or she may be Covered only once under this Blanket Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

### **SECTION 4: EFFECTIVE DATE OF INSURANCE**

A Covered Person will be insured on the latest of the following dates:

1. the Policy Effective Date; or
2. the date he or she is eligible.

A Dependent's insurance will not be in effect prior to the date a Covered Person is insured.

### **SECTION 5: TERMINATION DATE OF INSURANCE**

A Covered Person's coverage will end on the earlier of the date:

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

A Dependent's coverage will end on the earlier of the date:

1. he or she is no longer a Dependent;
2. the Covered Person's coverage ends;
3. the period ends for which premium is paid.

**SECTION 6: DESCRIPTION OF BENEFITS**

The following Provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits.

**PART I – INDEMNITY BENEFITS**

If Indemnity Benefits coverage is selected on the **Schedule**, We will pay the Benefit as shown below.

**[A. Accidental Death & Dismemberment, Loss of Sight, Speech or Hearing – Injury Only**

If Injury to a Covered Person results in any one of the losses listed below, we will pay the benefit shown for that loss. If the Covered Person suffers more than one loss as a result of any one accident, only the largest amount will be paid.

<b>For Loss of:</b>	<b>% of Principal Sum</b>
[Life	100%
Both Arms or Both Legs	100%
Both Hands and Both Feet	100%
One Arm and One Leg	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
Hearing	50%
Speech	50%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Permanent Damage to Sight of One Eye – up to Maximum Benefit of*	50%
One Thumb	10%
One Hallux (big toe)	10%
One Finger	5%
One Toe	5%
Each Joint of Thumb or Hallux	5%
Each Joint of Finger or Toe	1%
*See Vision Impairment Schedule below]	

**Loss** means, with reference to the hand or foot, a complete severance through or above the wrist or ankle joint; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the fingers and thumb, the complete severance at the metacarpophalangeal joint; with reference to the hallux and toes, the complete severance through the metatarsal phalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (if applicable) medial phalanx. Loss of sight, speech or hearing means the total and irrecoverable loss of sight, speech or hearing.

**Permanent Damage** means, with reference to sight, irreparable Injury that results in permanently impaired vision, but not in total and irrecoverable loss of vision. The following lists the amount payable for the degree of vision impairment due to Permanent Damage. The benefit paid for each eye will not be more than one half the Principal Sum. If the sight of an eye is less than 20/20 before the Permanent Damage, We will pay a benefit based upon the additional impairment due to the covered Injury. The amount shown in the Table applies separately to each eye.

<b>Vision Impairment Schedule</b>	<b>% of Principal Sum Payable for Each Eye</b>
20/20	0.0%
20/30	2.75%
20/40	5.5%
20/50	8.25%
20/60	11.0%
20/80	16.5%
20/100	22.0%
20/120	28.0%
20/150	36.0%
20/180	44.5%
20/200 or poorer	50.0%

If the Covered Person suffers more than one Covered Loss as a result of any one accident, multiple benefits under this benefit will be paid to the extent that one benefit does not duplicate another benefit. For example, if a Covered Person loses an arm in an accident, We will pay for "Loss of Arm" but not for "Loss of Hand," "Loss of Thumb," nor "Loss of Finger Joints."

If the Covered Person loses an arm and, in the same accident, is blinded in one eye, We will pay for both the "Loss of Arm" and the "Loss of Entire Sight in One Eye". However, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[B. Additional Loss of Life Benefit – Illness Only**

If a loss of life benefit is not payable under "A" We will pay the amount shown in the Schedule if death occurs due to Illness which is a direct result of participation in a Covered Activity; and

- (1) death occurs within 180 days of the date the Covered Person participated in the Covered Activity that caused such loss; or
- (2) a Physician or Hospital provided medical treatment to the Covered Person for such Illness within 90 days of the date the Covered Person participated in the Covered Activity that caused such loss.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[C. Additional Seat Belt Benefit – Injury Only**

If the loss of life benefit is payable under "A", We will pay an additional 25% of the Principal Sum if the Covered Person was in a motor vehicle and wearing a properly fastened seat belt when the Injury occurred that caused death.]

**[D. Post-traumatic Stress Disorder Benefit**

If the Covered Person suffers from a Post-traumatic Stress Disorder directly caused by an event during a specific single Covered Activity, We will pay the Reasonable and Customary Expenses incurred for inpatient or outpatient treatment up to the Maximum Limit in the Schedule. The event causing the Post-traumatic Stress Disorder must be witnessed during a Covered Activity that is outside the range of usual human experiences and would be markedly distressing to almost anyone, such as:

- (1) actual or threatened serious physical harm to the Covered Person's life or body;
- (2) witnessing actual or threatened serious physical harm to the life or body of other Covered Persons;
- (3) witnessing another person who has recently been or is being seriously injured or killed as a result of an accident or physical violence.]

**[PART II – PERMANENT PHYSICAL IMPAIRMENT BENEFIT – INJURY ONLY**

If Permanent Physical Impairment Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results in Permanent Physical Impairment, We will pay this benefit only if the Covered Person:

- (1) is Totally Disabled or Partially Disabled as a result of such Injury; and
- (2) has participated in an approved physical rehabilitation program, if the physical condition so warrants, and has reached their Maximum Medical Improvement.

The examining Physician must certify that the Covered Person is suffering from a Permanent Physical Impairment, and has reached their Maximum Medical Improvement.

Permanent Physical Impairment will be assigned an impairment value by an examining Physician. This value will be expressed as a percentage in relation to the whole person. The impairment value will be determined by the most current edition of the American Medical Association's *Guides to the Evaluation of*

*Permanent Impairment.* (In the event the referenced guide ceases to be published, We will use another appropriate measurement of impairment values.) This percentage value will be applied to the benefit shown in the Schedule to determine the amount payable under the Policy. If the Covered Person has a prior physical impairment, the impairment value that represents the prior physical impairment will be deducted from the Permanent Physical Impairment evaluation.

If the Covered Person has an impairment value of 90% or higher, we will pay 125% of the Permanent Physical Impairment Benefit – Injury Only principal sum shown in the Schedule.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 125% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[PART III – PERMANENT PHYSICAL IMPAIRMENT BENEFIT – ILLNESS ONLY**

If Permanent Physical Impairment Benefit – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

The Permanent Physical Impairment Benefit – Illness Only shown in the Schedule is payable if Illness to a Covered Person results in 5 years (260 weeks) of Total Disability Benefits.

**The benefit is payable as follows:**

- (1) [If the Covered Person is unable to return to his or her Regular Occupation after 5 years (260 weeks) of receiving Total Disability Benefits, 50% of the Permanent Physical Impairment Benefit – Illness Only principal sum shown in the Schedule is payable.]
- (2) [If the Covered Person is unable to return to any occupation after 5 years (260 weeks) of receiving Total Disability Benefits, 75% of the Permanent Physical Impairment Benefit – Illness Only principal sum shown in the Schedule is payable.]
- (3) [If, after 5 years (260 weeks) of receiving Total Disability Benefits, the Covered Person has been approved for Social Security disability benefits or, if not eligible for Social Security disability benefits, otherwise meets the eligibility criteria for Social Security disability benefits, 125% of the Permanent Physical Impairment Benefit – Illness Only principal sum shown in the Schedule is payable.]

The five year (260 week) period of Total Disability must be payable as a result of one Illness sustained while participating in the same Covered Activity.

If a Covered Person has received a Permanent Cardiac Impairment Benefit and later becomes eligible for payment under this benefit for the same condition, the amount payable under this benefit is the Permanent Physical Impairment Benefit – Illness Only amount shown in the Schedule, less the amount previously paid under the Permanent Cardiac Impairment Benefit – Illness Only. The percentage schedule as described in the second paragraph of this Part III will also apply to the total amount payable.

If the Covered Person receives this benefit, any right to collect benefits under any Weekly Disability Benefit of the Policy will end with the payment of this benefit.]

**[PART IV – WEEKLY DISABILITY PERMANENT PHYSICAL IMPAIRMENT BENEFIT – INJURY ONLY**

If Weekly Disability Permanent Physical Impairment Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results in a Permanent Physical Impairment and it is determined that the Covered Person has a whole person Permanent Physical Impairment due to an Injury, we will pay the Weekly Disability Permanent Physical Impairment Benefit – Injury Only as shown in the Schedule. A whole person Permanent Physical Impairment due to an Injury means the percentage value of 50% or greater for purposes of the Weekly Disability Permanent Physical Impairment Benefit.

The Covered Person must elect to accept this weekly disability benefit and notify Us of such election by registered mail within the Period of Eligibility. If no election is made within the Period of Eligibility, We will notify the Covered Person and the Period of Eligibility will be extended an additional 90 days. If the Covered Person does not notify Us by registered mail of the election to accept the payment under this

benefit prior to the expiration of the 90-day extension period, the Covered Person will lose the right to claim this benefit.

However, under no circumstances will We pay a benefit under this Part IV if We are notified of the Covered Person's election to accept the benefit more than 5 years (260 weeks) after the date of the Injury that caused the Permanent Physical Impairment, even if such notification is received during the Period of Eligibility or the 90-day extension period described above.

This Weekly Disability Permanent Physical Impairment Benefit will be paid for the remainder of the Covered Person's lifetime.

The Weekly Disability Permanent Physical Impairment Benefit will be determined by multiplying the Weekly Disability Benefit - Injury only amount payable on the 29th day of Total Disability, as determined under Part IX of the Policy, by the percentage value of the Covered Person's Permanent Physical Impairment.

The Permanent Physical Impairment rating due to an Injury used to determine the Weekly Disability Permanent Physical Impairment Benefit is final upon initiation of Weekly Disability Permanent Physical Impairment Benefits. Subsequent changes in the Injury Rating of the Permanent Physical Impairment, if any, will not affect the Weekly Benefits paid or payable under this Part IV.

The benefit payable under this Part IV will be paid in addition to any benefits paid or payable under the Policy, except those paid or payable under Part IX.]

**[PART V – COSMETIC BURN DISFIGUREMENT BENEFIT – INJURY ONLY**

If Cosmetic Burn Disfigurement Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person suffers from disfigurement due to a burn that is classified as a third or fourth degree burn as the result of an Injury, We will pay this benefit.

All benefits payable are based on a percentage of the Principal Sum shown in the Schedule for this benefit and depend on the area of the body that was burned. Each body part is assigned a percentage relative to its visual exposure. The benefit payable for any one loss is determined by multiplying the percentage of body surface actually burned times the maximum percentage of the Principal Sum payable. The attending Physician will determine the percentage applicable to each burn. The list below shows the maximum percentage of the Principal Sum, by body part.

Body Part	% of Principal Sum
Face, Neck, Head	100%
Torso (Front)	35%
Torso (Back)	35%
Hand & Forearm (Right)	25%
Hand & Forearm (Left)	25%
Upper Arm (Right)	15%
Upper Arm (Left)	15%
Thigh (Right)	10%
Thigh (Left)	10%
Lower Leg (Right, below knee)	10%
Lower Leg (Left, below knee)	10%

For example, by using the Burn Disfigurement Schedule above:

- (1) if the entire surface of the hand and forearm were burned the benefit would be 25% of the Principal Sum; or
- (2) if 50% of surface of the hand and forearm were burned the benefit would be 50% of 25%, or 12.5% of the Principal Sum.

The above list only represents the maximum percentage of the Principal Sum payable for any one Covered Loss. If the Covered Person suffers burns in more than one area as a result of any one accident, the total of benefits for all such burns will not exceed 100% of the Principal Sum.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[PART VI – PERMANENT CARDIAC IMPAIRMENT BENEFIT – ILLNESS ONLY**

If Permanent Cardiac Impairment Benefit – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If the Covered Person suffers a Permanent Cardiac Impairment (PCI) as a result of a heart condition, We will pay a percentage of the Principal Sum shown in the Schedule if:

- (1) the heart condition was sustained as a result of a Covered Activity; and
- (2) it resulted in at least [26] weeks of Total Disability; and
- (3) the Covered Person had a Left Ventricular Ejection Fraction greater than [35%] prior to the date of the Covered Activity.

The Covered Person's highest Left Ventricular Ejection Fraction (LVEF) and lowest New York Heart Association (NYHA) Functional Classification ratings will be obtained not more than 12 months after the Covered Activity that caused the heart condition. The ratings must have been determined following the date of the Covered Activity. The ratings will be used to determine the base benefit amount from the PCI Chart below.

**PCI Chart**

[LVEF	NYHA Functional Class	% of Principal Sum
< 21% Function	IV	100%
< 21% Function	II or III	75%
21 – 25% Function	IV	75%
21 – 25% Function	II or III	50%
26 – 30% Function	IV	50%
26 – 30% Function	II or III	25%]

The base benefit amount will then be adjusted based on the Covered Person's age on the date of the Covered Activity that caused the heart condition using the Age Adjustment Chart below.

**Age Adjustment Chart**

[Covered Person's Age	Benefit Due %
40 or younger	125% of Base Benefit
41 – 65	75% of Base Benefit
66 or older	50% of Base Benefit]

The benefit due is calculated by multiplying the Principal Sum by the % of Principal Sum in the PCI Chart by the Benefit Due % in the Age Adjustment Chart. For Example: A 35 year old with a LVEF of 24% and a NYHA Functional Class of III would be due 62.5% if the Principal Sum.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[PART VII – MEDICAL EXPENSE BENEFIT – INJURY ONLY**

If Medical Expense Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Medical Expenses** – If, as the result of Injury, a Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum Benefit shown in the Schedule for this benefit, except as may be provided in "B" below.

**B. Additional for Plastic Surgery Expenses** – We will pay an additional benefit if a Covered Person requires skin grafting or plastic surgery due to an Injury covered under "A" above. The maximum amount We will pay for this benefit is shown in the Schedule.]

**[PART VIII – MEDICAL EXPENSE – ILLNESS ONLY**

If Medical Expense – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Medical Expense** – If Illness begins within [0, 30, 60, 90 days] and results from the Covered Person's participation in the Covered Activity, and the Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum Benefit shown in the Schedule for this benefit, except as may be provided in "B" below.

**B. Preventative Inoculations** – We will pay the Reasonable and Customary Expense incurred for preventative inoculations received within 60 days of the date of a Covered Person's participation in a Covered Activity that caused exposure to a Illness including any additional expenses due to an allergic reaction to any preventative inoculations administered to the Covered Person subject to the Maximum Benefit shown in the Schedule.]

**[PART IX – WEEKLY DISABILITY BENEFIT – INJURY ONLY**

If Weekly Disability Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Total Disability Benefit**

We will pay benefits under this benefit "A" for Total Disability if such disability occurs as a direct result of Injury. The Injury must be the direct result of the Covered Person's participation in a Covered Activity.

We will pay the full weekly benefit shown in the Schedule for each week of the first 4 weeks of Total Disability. After the first 4 weeks of Total Disability, We will pay up to twice the weekly benefit shown in the Schedule, but not more than 100% of the Covered Person's Average Weekly Wage for such continued disability. In no event will We pay a benefit that is less than 25% of the weekly benefit shown in the Schedule for continued Total Disability.

Total Disability Inflation Provision – After the first 2 years of Total Disability for which We have paid benefits, We will increase additional benefits paid for that Total Disability. We will increase the benefit by 3% (compounded annually) for each additional year the Covered Person continues to be eligible for Total Disability benefits.

**B. Partial Disability Benefit**

We will pay benefits under this benefit "B" for Partial Disability if such disability occurs as a direct result of Injury. The Injury must be:

- (1) the direct result of the Covered Person's participation in a Covered Activity; or
- (2) immediately following a period of Total Disability for which a benefit was paid under "A".

If the Partial Disability is the direct result of the Covered Person's participation in a Covered Activity, We will pay 50% of the weekly benefit shown in the Schedule for each of the first 4 weeks of Partial Disability. If the Partial Disability is immediately following a period of Total Disability for which a benefit was paid under "A", We will pay up to 50% of the weekly benefit shown in the Schedule but not more than 50% of the Covered Person's Average Weekly Wage for each of the first 4 weeks of Partial Disability.

After the first 4 weeks of Partial Disability, We will pay up to the full weekly benefit shown in the Schedule but no more than 50% of the Covered Person's Average Weekly Wage. In no event will We pay less than 12.5% of the weekly benefit shown in the Schedule.

**Disability Provisions**

No benefits will be paid under this benefit after the date a benefit has been paid under the Permanent Physical Impairment Benefit – Injury Only.

Benefits for Total Disability as a result of any one Injury will not be paid for more than [5 years (260 weeks); 10 years (520 weeks)]; [the lifetime of the Covered Person]. Benefits for Partial Disability will not be paid for more than [1 year (52 weeks); 5 years (260 weeks)] as a result of any one Injury. For any disability benefit of less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day of disability up to the applicable maximum.

If the Covered Person returns to his or her Regular Occupation on a full or part time basis within 5 years of the date of the Injury and, after receiving benefits for Total Disability, he is thereafter unable to perform the material and substantial duties of his or her Regular Occupation, he may return to a Total Disability status provided the attending Physician certifies a return to Total Disability status.

Periods of Total Disability or Partial Disability separated by less than 26 weeks will be considered one period of disability unless due to separate and unrelated causes

In the event the disability benefits received under the Policy plus disability benefits received under Workers' Compensation and any Other Valid and Collectible Insurance exceed the limits of "A" or "B", benefits will be reduced. Benefits will be reduced so the Covered Person will receive no more than 100% of his or her Average Weekly Wage for Total Disability under "A" and not more than 50% of his or her Average Weekly Wage for Partial Disability under "B". This will not affect the minimum benefit amount outlined above of 25% for Total Disability or 12.5% for Partial Disability.

[If a Covered Person is approved for disability retirement or otherwise retires, any retirement income offsets the Disability Benefits payable under this Policy.]

#### **[PART X – WEEKLY DISABILITY BENEFIT – ILLNESS ONLY**

If Weekly Disability Benefit – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

##### **A. Total Disability Benefit**

We will pay benefits under this benefit "A" for Total Disability if such disability occurs as a direct result of Illness. The Illness must be the direct result of the Covered Person's participation in a Covered Activity.

We will pay the full weekly benefit shown in the Schedule for each week of the first [4] weeks of Total Disability. After the first [4] weeks of Total Disability, We will pay up to twice the weekly benefit shown in the Schedule, but not more than 100% of the Covered Person's Average Weekly Wage for such continued disability. In no event will We pay a benefit that is less than [25%] of the weekly benefit shown in the Schedule for continued Total Disability.

Total Disability Inflation Provision – After the first 2 years of Total Disability for which We have paid benefits, We will increase additional benefits paid for that Total Disability. We will increase the benefit by 3% (compounded annually) for each additional year the Covered Person continues to be eligible for Total Disability benefits.

##### **B. Partial Disability Benefit**

We will pay benefits under this benefit "B" for Partial Disability if such disability occurs as a direct result of Illness. The Illness must be:

- (1) the direct result of the Covered Person's participation in a Covered Activity; or
- (2) immediately following a period of Total Disability for which a benefit was paid under "A" above.

If the Partial Disability is the direct result of the Covered Person's participation in a Covered Activity, We will pay 50% of the weekly benefit shown in the Schedule for each of the first 4 weeks of Partial Disability. If the Partial Disability is immediately following a period of Total Disability for which a benefit was paid under "A", We will pay up to 50% of the weekly benefit shown in the Schedule but not more than 50% of the Covered Person's Average Weekly Wage for each of the first 4 weeks of Partial Disability.

After the first 4 weeks of Partial Disability, We will pay up to the full weekly benefit shown in the Schedule but no more than 50% of the Covered Person's Average Weekly Wage. In no event will We pay a benefit less than 12.5% of the weekly benefit shown in the Schedule.

## **Disability Provisions**

No benefits will be paid under this benefit after the date a benefit has been paid under the Permanent Cardiac Impairment Benefit.

Benefits for Total Disability as a result of any one Illness will not be paid for more than [5 years (260 weeks); 10 years (520 weeks)] [or] [to age [67].] [whichever is longer]. Benefits for Partial Disability will not be paid for more than [1 year (52 weeks); 5 years (260 weeks)] as a result of any one Illness. For any disability benefit of less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day of disability up to the applicable maximum.

If the Covered Person returns to his or her Regular Occupation on a full or part-time basis after receiving benefits for Total Disability, and he is unable to perform the material and substantial duties of his or her Regular Occupation, he may return to Total Disability status provided the attending Physician certifies a return to Total Disability status.

Periods of Total Disability or Partial Disability separated by less than 26 weeks will be considered one period of disability unless due to separate and unrelated causes.

In the event the disability benefits received under the Policy plus disability benefits received under Workers' Compensation and any Other Valid and Collectible Insurance exceed the limits of "A" or "B", benefits will be reduced. Benefits will be reduced so the Covered Person will receive no more than 100% of his or her Average Weekly Wage for Total Disability under "A" nor more than 50% of his or her Average Weekly Wage for Partial Disability under "B". This will not affect the minimum benefit amount outlined above of 25% for Total Disability or 12.5% for Partial Disability.

[If a Covered Person is approved for disability retirement or otherwise retires, any retirement income offsets the Disability Benefits payable under this Policy.]

### **[PART XI – FAMILY EXPENSE BENEFIT – INJURY OR ILLNESS**

If Family Expense Benefit – Injury Or Illness coverage is selected on the Schedule, We will pay the Benefit as shown below.

If We pay benefits under Part I, Part II, Part III, Part VII or Part VIII, We will also pay the following additional benefits for the Reasonable and Customary Expenses incurred on behalf of the Covered Person within 52 weeks of the date of Injury or Illness:

- (1) medically necessary family counseling;
- (2) training of an Immediate Family member to perform rehabilitative or custodial functions necessary to the rehabilitation or care of the Covered Person;
- (3) transportation, meals and lodging expenses of the Immediate Family members incurred for visiting the Covered Person if he is receiving medical treatment on an inpatient basis more than 35 miles from the Covered Person's permanent residence;
- (4) loss of earnings by a Covered Person's Immediate Family member not to exceed 100% of the individual Immediate Family member's Average Weekly Wage, due to and as a direct result of a covered Injury or Illness sustained by the Covered Person.

The Maximum Benefit payable under this benefit is shown in the Schedule.]

### **[PART XII – FAMILY EDUCATION BENEFIT**

If Family Education Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If benefits are payable for the loss of life of a Covered Person under Part I, We will also pay the following benefits:

**A. Dependent Child Benefit**

We will pay the annual tuition actually incurred at an Institution of Higher Learning, excluding room and board, by each Dependent Child of the deceased Covered Person. This benefit is payable only if on the date of the Covered Person's death, the Dependent Child is:

- (1) enrolled as a full time student at an Institution of Higher Learning above the 12<sup>th</sup> grade level; or
- (2) under age 21 and enrolls as a full time student at an Institution of Higher Learning above the 12<sup>th</sup> grade level within 24 months of the date of the Covered Person's death.

If the Dependent Child remains continuously enrolled as a full time student at such institution, We will pay up to the Maximum Benefit shown in the Schedule for this benefit for each year the Dependent Child is enrolled at such institution, for up to 4 consecutive years.

**B. Surviving Spouse or Domestic Partner Benefit**

We will pay the annual tuition actually incurred at an Institution of Higher Learning, excluding room and board, by the Surviving Spouse or Domestic Partner of the deceased Covered Person. This benefit is payable only if the Surviving Spouse or Domestic Partner enrolls in an Institution of Higher Learning within 48 months of the date of the Covered Person's death.

We will pay up to the Maximum Benefit shown in the Schedule for this benefit for each year the Surviving Spouse is enrolled at such institution, for up to 4 consecutive years.

**C. Other Benefit**

If no person qualifies for the benefits described in "A." or "B." above, We will pay a benefit of \$5,000 to the Covered Person's primary beneficiary. If no beneficiary is named We will pay the amount to the Covered Person's estate. We will not pay more than a total benefit of \$5,000 under this benefit "C".]

**[PART XIII – ATHLETICS AND SPECIAL EVENTS BENEFIT – INJURY ONLY**

If Athletics And Special Events Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results from participation in or travel directly to or from Athletic Games, Contests or Special Events, We will pay the following:

**A. Medical Expense Benefit – Injury only**

If, as the result of Injury, a Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum shown in the Schedule for one Injury.

**B. Total Disability Benefit – Injury Only**

We will pay the weekly benefit for this benefit "B" if the Covered Person becomes Totally Disabled within 30 days after the date of Injury. For any Total Disability benefit paid for less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day the Covered Person is disabled up to the applicable maximum. We will pay up to a maximum of 52 weeks for any one accident.]

**[PART XIV – HIV BENEFIT**

If HIV Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. HIV Lump Sum Benefit**

We will pay the Principal Sum for this benefit "A" if a Covered Person becomes infected with the Human Immunodeficiency Virus (HIV) as a direct result of participation in a Covered Activity. Payment made by Us under the Policy will end any right to collect any other benefits under the Policy. This benefit will be paid only if:

- (1) the Covered Person suffers exposure to HIV as a direct result of participating in a Covered Activity. Exposure means mucous-membrane, eye, or skin contact with blood, blood products, or other potentially infectious body fluids from a person with known HIV-positive serostatus, one clinically diagnosed with AIDS, or a high-risk person with compatible signs and symptoms; and

- (2) an incident report describing how the Covered Person was exposed to HIV is filed with the Policyholder within 72 hours of participation in the Covered Activity during which the Covered Person was exposed to HIV; or
- (3) the date on which the Covered Person became aware of such exposure; and
- (4) the incident report described in (2) above is filed with Us within 7 days of the date that it was filed with the Policyholder; and
- (5) the Covered Person is tested for the presence of HIV antibodies in their blood within 7 days of the date such report was filed with Us, and, must test negative utilizing a preliminary screening test approved by the Federal Food & Drug Administration (FDA); and
- (6) the Covered Person tests positive for the presence of HIV antibodies in their blood within 52 weeks of participation in the Covered Activity during which the Covered Person was exposed to HIV utilizing a positive screening test approved by the FDA.

We will pay for the Reasonable and Customary Expense of the tests described in (5) and (6) above.]

**[B. HIV Infection Prevention Benefit**

We will pay the Reasonable and Customary Expense of postexposure prophylaxis if a Covered Person suffers exposure to HIV as a direct result of participation in a Covered Activity. Exposure means mucous-membrane, eye, or skin contact with blood, blood products, or other potentially infectious body fluids from a person with known HIV-positive serostatus, one clinically diagnosed with AIDS, or a high-risk person with compatible signs and symptoms. This benefit will be paid only if such prophylaxis is recommended by the attending Physician; and it complies with the HIV postexposure prophylaxis (PEP) guidelines of the Center for Disease Control and Prevention (CDC), an agency of the U.S. Department of Health and Human Services.

If the Covered Person participates in an HIV PEP Protocol in accordance with this benefit "B" and as a direct result suffers loss of life, We will pay an amount equal to the Principal Sum shown in the Schedule for benefit "A" of this Part XII.

In no event will death benefits be paid or payable under this benefit "B" if a death benefit is paid or payable under benefit "A" of this Part XII as a result of participation in the same Covered Activity.

We will not pay more than the Maximum shown in the Schedule.]

**[PART XV – PHYSICAL ASSAULT BENEFIT – INJURY ONLY**

If Physical Assault Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

A. If a benefit is payable for Injury under Part I, Part II or Part III of the Policy, We will pay an additional benefit equal to 25% of the total benefit paid under such Part I, Part II or Part III, or the Maximum shown in the Schedule for this Part XIII, whichever is more, if such Injury is caused by Physical Assault committed by a person other than a Covered Person, while traveling to or from emergency duty or while at the emergency duty.

B. If no benefit is payable for Injury under Part I, Part II or Part V of the Policy, but benefits are payable for Injury under "A" or "B" of Part VII or Part VIII of the Policy, We will pay an additional lump sum benefit equal to the Maximum shown in the Schedule, if such Injury is caused by Physical Assault committed by a person other than a Covered Person.]

**[PART XVI – DAY CARE EXPENSE BENEFIT – INJURY OR ILLNESS**

If Day Care Expense Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person is Totally Disabled as a result of Injury or Illness and benefits are payable under Part VII, Part VIII, Part IX or Part X of the Policy, and the Day Care Expense is incurred solely as a result of the covered Injury or Illness, We will pay an additional benefit up to the Maximum shown in the Schedule for Day Care Expense necessarily incurred by the Covered Person during the period of Total Disability.]

**[PART XVII – PERMANENT PHYSICAL IMPAIRMENT EDUCATION BENEFIT – INJURY ONLY**

If Permanent Physical Impairment Education Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results in Permanent Physical Impairment, We will pay this benefit only if the Covered Person:

1. is Totally Disabled or Partially Disabled as a result of such Injury; and
2. has participated in an approved physical rehabilitation program, if his or her physical condition so warrants, and has reached their Maximum Medical Improvement; and
3. ~~We pay elects to accept a~~ lump sum benefit under Part II, ~~and notifies Us of such election by registered mail within the Period of Eligibility.~~

Determination of the Benefit Payable:

We will provide this benefit upon a written agreement between the Covered Person and Us for the program of education for retraining in an Institution of Higher Learning. Coverage will include charges for tuition and books as specified in the written agreement. Tuition must be incurred for the purpose of learning a new skill or trade and with the reasonable expectation that the Covered Person may find gainful employment as a result. We will not pay this benefit for any tuition incurred by the Covered Person more than 156 weeks after the end of the Period of Eligibility. We will not pay more than the Maximum shown in the Schedule.

We will not pay for the cost of any tuition incurred by a Covered Person that is paid or payable under Workers' Compensation or any Other Valid and Collectible Insurance.]

**[PART XVIII – RESIDENCE AND VEHICLE ADAPTATION EXPENSE BENEFIT**

If Residence and Vehicle Adaptation Expense Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If the Covered Person suffers an Injury or Illness which results in a permanent irrevocable loss for which benefits are payable under this Policy and inhibits the Covered Person's ability to maintain independence in their residence or vehicle, We will pay up to the benefit shown in the schedule if:

- (1) the Residence and Vehicle Adaptation Expense was not necessary prior to the Covered Activity that caused the Injury or Illness; and
- (2) Residence and Vehicle Adaptation Expenses are incurred as a direct result of the Injury or Illness; and
- (3) the Residence and Vehicle Adaptation Expenses are incurred within 12 months of Covered Activity that caused the Injury or Illness;
- (4) Residence and Vehicle Adaptation Expenses are made in accordance with any applicable laws or requirements for approval by the appropriate government authorities;
- (5) Residence and Vehicle Adaptation Expenses are made by a person or persons experienced in such alterations and such alterations or modifications are recommended and approved by a recognized organization, providing support and assistance to impaired individuals; and
- (6) the Residence and Vehicle Adaptation Expenses are agreed to and approved by Us.

We will pay up to the Maximum Benefit shown in the Schedule for this benefit for:

1. The one-time cost of alterations to the injured Covered Person's residence to make it accessible and habitable for an impaired individual; and
2. The one-time cost of modifications necessary to a motor vehicle, owned by the injured Covered Person, to make the vehicle accessible or drivable for the Covered Person.

We will pay the Residence and Vehicle Adaptation Expenses in excess of benefits received under Workers' Compensation and any Other Valid and Collectible Insurance.]

**[PART XIX – CONTINUATION OF COVERAGE BENEFIT – INJURY ONLY**

If Continuation of Coverage – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person is Totally Disabled as a result of Injury and benefits are payable under Part II, Part VII or Part VIII of the Policy, We will pay the cost of group medical insurance coverage up to a maximum of \$500 per month for up to a total maximum of \$6,000, not to exceed 18 months. The Covered Person must purchase the group medical insurance coverage on an individual basis from his or her former employer pursuant to any available continuation of coverage and during the period of Total Disability payable under the Policy.

Coverage will only apply if the Covered Person provides Us with acceptable documentation from his or her employer stating that the sole reason that the Covered Person is eligible for continuation benefits is because his or her employment was terminated because of his or her Total Disability.]

**[PART XX – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT – INJURY ONLY  
[Off-Duty Coverage] [24-Hour Coverage]**

If Accidental Death and Dismemberment Benefit – Injury Only is selected on the Schedule, We will pay the Benefit as shown below.

**A. Loss of Life**

If Injury to a Covered Person results in loss of his or her life, We will pay a benefit under this Part XX. The benefit amount We will pay is shown in the Schedule.

**B. Dismemberment Loss**

If Injury to a Covered Person results in a dismemberment loss listed in Part I “A” in the Policy, We will pay a benefit for such loss under this Part XX. The benefit amount We will pay is shown in the Schedule.

**C. Loss of Life – Military Duty**

If Injury to a Covered Person results in loss of his or her life while serving in the military, armed forces or units auxiliary thereto, We will pay a benefit under this Part XX. The benefit amount We will pay is shown in the Schedule. Exclusion (3) of Section 8 Exclusions does not apply to this benefit.

[Benefit XX A. and B. will not be paid if a benefit is paid under Part I “A” of the Policy.]]

**[PART XXI – BURIAL AND CREMATION BENEFIT**

If Burial and Cremation Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

We will pay the amount shown in the Schedule for burial or cremation of the Covered Person who dies from an Injury or Illness resulting directly; and independently of all other causes; from a Covered Activity.]

**[PART XXII – SURVIVOR BENEFITS**

If Survivor Benefits coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Child**

We will pay this benefit shown in the Schedule of Benefits subject to the following conditions, if the Covered Person’s death results directly; and independently of all other causes; from a Covered Activity and he or she is survived by a Covered Dependent Child.

If the Covered Dependent Child was under the age of majority at the time of the Covered Person’s death, a Child Survivor Benefit, plus interest, will be paid in one lump sum to each surviving Covered Dependent Child when he or she attains the age of majority. Interest will be compounded annually at a rate equal to the arithmetic average of the 52-week U.S. Treasury notes as published by a financial authority designated by Us. If the Covered Dependent child dies before this benefit is payable, this benefit will then be payable to the Covered Dependent Child’s estate.

If a surviving Covered Dependent Child is the age of majority or over at the time of the Covered Person’s death, the benefit will be payable in one lump sum when We receive the claim. If there is no surviving Covered Dependent Child at the time of the Covered Person’s death, a default benefit will be paid to the Covered Person’s beneficiary.

Benefits will not be paid if a claim is submitted to Us more than one year after the Covered Person's death, or if submitted earlier and he or she is under the age of majority at the time of the Covered Person's death, the child is not a Covered Dependent.

**B. Spouse or Domestic Partner**

We will pay this benefit shown in the Schedule of Benefits if the Covered Person's death results directly; and independently of all other causes; from a Covered Activity and he or she is survived by a Surviving Spouse or Domestic Partner.

**C. Elder**

We will pay this benefit shown in the Schedule of Benefits if the Covered Person's death results directly; and independently of all other causes; from a Covered Activity and he or she is survived by a Dependent Parent.

The Elder Survivor Benefit will be payable in equal shares to the Dependent Parents. Only one Elder Survivor Benefit will be payable regardless of the number of Dependent Parents.

Dependent Parent(s) means the Covered Person's parent; parent-in-law; grandparent; grandparent-in-law; great-grandparent; or great-grandparent-in-law (whether natural; step; or adoptive), who is:

- (1) not regularly employed on a full-time basis;
- (2) primarily dependent upon the Covered Person for support and maintenance due to a proven mental disability or physical handicap;
- (3) residing in the Covered Person's home; and
- (4) eligible to be claimed as an exemption on the Covered Person's federal income tax return.]

**[PART XXIII – TRANSITION BENEFIT**

If Transition Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person is given a release to return to his or her primary employer after having received benefits under this Policy for a Covered Injury or Covered Illness, but his or her primary employer has terminated his or her employment due to the Covered Injury or Covered Illness, we will continue to pay disability benefits previously payable for a period of up to 26 weeks while the Covered Person actively seeks employment.]

**[PART XXIV – CRITICAL/TRAUMATIC INCIDENT STRESS MANAGEMENT TEAM BENEFIT**

If Critical/Traumatic Incident Stress Management Team coverage is selected on the Schedule, We will pay the Benefit as shown below.

We will pay the reasonable and customary expenses incurred by a Critical Incident Stress Management Team when such services are: (1) requested and authorized by the Policyholder; and (2) are required as a result of the Covered Person's participation in a specific Covered Activity in which a Traumatic Incident occurred while coverage under this Policy is in force. Covered expenses are those for necessary transportation, meals, and lodging. We will not pay more than the Maximum shown in the Schedule regardless of the number of Covered Persons treated.

**[PART XXV EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFIT**

If Emergency Medical Evacuation and Repatriation Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

We will pay Covered Expenses incurred up to the maximum shown in the Schedule , subject to the following conditions for emergency medical evacuation, if:

- 1. The Covered Person suffers a Covered Loss resulting directly; and independently of all other causes; from a Covered Accident that occurs while traveling from his or her principal residence to another city or foreign country, with at least {100} miles distance.

- The Covered Person's attending Physician certifies an emergency need to send the Covered Person, under medical supervision, to [the nearest] [a different] medical facility.

Covered expenses include:

- charges for ambulance services required while transporting the Covered Person to the nearest appropriate treatment facility; or
- charges for medical services required to send the Covered Person to the nearest appropriate treatment facility; or
- reimbursement of [economy] [business] [first] class transportation charges for return of the Covered Person from the treatment facility to home, paid for by the Covered Person within 1 year (52 weeks) from the date he or she was first scheduled to return from the trip. Any refunds paid or payable from the unused transportation tickets will reduce benefits; or
- charges for necessary travel expenses of an escort; such travel expenses are limited to food; hotel room; and economy class transportation charges; and
- the charges incurred that are medically necessary and do not exceed the usual and customary charges for similar treatment, services, or supplies in the locality where the expense is incurred; and do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless: We authorize in writing, or by an authorized electronic means, all expenses in advance, and services are rendered by Our assistance provider. The Covered Person must, at his or her own expense, furnish: travel invoices, medical reports or records, or other documents We require to determine if benefits are payable. Benefits will be paid to the party who actually paid for the expenses upon Our receipt of satisfactory proof that the expense was paid.

If the Covered Person pays eligible expenses for a Covered Loss for which We believe a third party is liable, We will pay the benefits for emergency medical evacuation. However, if the Covered Person recovers payment from the third party, he or she must refund to Us the lesser of:

- the amount We paid for the eligible expenses; or
- an amount equal to the sum received from the third party for such expenses.

Benefits will not be paid for any of the following:

- expenses that exceed the Maximum Benefit;
- services not pre-approved by Us, or for services performed by a vendor not authorized by Us; or
- expenses paid or payable by any Workers' Compensation, occupational disease or similar law that would pay emergency medical evacuation expenses in the absence of this benefit.]

#### **[PART XXVI REPATRIATION BENEFIT]**

We will pay Eligible Expenses, as shown in the Schedule of Benefits, incurred for the return of the Covered Person's remains to his or her place of residence in his or her home country and state if the Covered Person's death results directly, and independently of all other causes; from a Covered Accident outside of his or her home state or more than {1 00} miles from the Covered Person's place of residence.

"Eligible Expenses" means costs, pre-approved by Us and incurred for embalming; cremation; coffin or urn; transportation of the body or remains; necessary travel expenses of an escort. Necessary travel expenses are limited to food; hotel room; and economy class transportation charges.]

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#### **[PART XXVII] - OPTIONAL BENEFITS**

If one or more Optional Benefits are selected on the Schedule, We will pay the Benefit(s) as shown below.

##### **A. [Additional Weekly Disability Benefit]**

If a Covered Person becomes Totally Disabled and is eligible for benefits under Part IX or Part X of the Policy, We will pay an additional weekly disability benefit. We will pay this benefit for the first week the Covered Person is Totally Disabled. For less than 1 week, We will pay one-seventh (1/7) of the weekly benefit for this benefit for each full day of Total Disability. We will pay this in addition to any other weekly benefit payable under the Policy.]

**[B. Weekly Hospital Indemnity Benefit**

We will pay a weekly hospital indemnity benefit if:

- 1. benefits are also payable under Part IX or Part X of the Policy; and
- 2. the Covered Person requires Hospital confinement for any Injury or Illness.

This benefit starts on the first day the Covered Person is confined in a Hospital. We will pay one-seventh (1/7) of the weekly benefit for this Benefit for each day of confinement. We will not pay for more than 104 weeks as a result of any one Injury or Illness.]

**[C. Auxiliary Member Benefits – Injury Only**

If Injury to a Covered Auxiliary Member results from participation in a Covered Activity, We will pay the following:

**1. Indemnity Benefits**

We will pay for the losses listed in "A" of Part I of the Policy, subject to the Principal Sum listed in the Schedule for this benefit if an Injury results in a Covered Loss.

**2. Medical Expense Benefit**

If as the result of an Injury, an Auxiliary Member is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum shown in the Schedule.

**3. Weekly Disability Benefit**

We will pay the weekly benefit shown in the Schedule if the Auxiliary Member becomes Totally Disabled within 30 days after the date of Injury. For any benefit provided for less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day the Auxiliary Member is Totally Disabled up to the applicable maximum. We will pay up to a maximum of 1 year (52 weeks) for any one accident.

]

**[D. Organized Team Sports Benefit**

We will pay the benefits described below if a Covered Person suffers a Sports Injury:

**1. Accidental Death and Dismemberment or Loss of Sight**

If Sports Injury to a Covered Person results in loss of his or her life, We will pay the Principal Sum shown in the Schedule for this benefit. If Sports Injury to a Covered Person results in any one of the other losses listed below, We will pay a percentage of the Principal Sum shown in the Schedule for that loss as listed below:

<u>For "Loss" of:</u>	<u>% of Principal Sum</u>
One Arm	75%
One Leg	75%
One Hand	50%
One Foot	50%
Entire Sight of One Eye	50%

"Loss" means, with reference to the hand or foot, the complete severance through or above the wrist or ankle joint; and with reference to the arm or leg, the complete severance through or above the elbow or knee joint. Loss of sight means the total and irrecoverable loss of sight.

If the Covered Person suffers more than one Covered Loss as a result of any one accident, multiple benefits under "1" above will be paid to the extent that one benefit does not duplicate another benefit of the Policy.

For example, if a Covered Person loses an arm in an accident, we will pay for "Loss of One Arm" but not for "Loss of One Hand." If the Covered Person loses an arm and, in the same accident, is blinded in one eye, we will pay for "Loss of One Arm" and "Loss of Entire Sight in One Eye." However, under

no circumstances, will we pay more than 100% of the Principal Sum shown in the Schedule for this benefit for all Covered Losses resulting from any one accident.

## **2. Medical Expense**

If, as the result of a Sports Injury, and beginning within 90 days of the date the Sports Injury occurred, a Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care, We will pay the Reasonable and Customary Expense incurred for such services.

We will not pay more than the Maximum shown in the Schedule for this benefit. We will not pay for any expenses incurred more than 1 year (52 weeks) after the date that the Sports Injury occurred. We will only pay for those expenses that are in excess of the Medical Expense Deductible shown in the Schedule for this benefit.

## **3. Weekly Disability**

We will pay the Disability Benefit shown in the Schedule for this benefit if the Covered Person becomes Totally Disabled within 30 days after the date the Sports Injury occurred. We will pay the Disability Benefit for each week that the Covered Person remains Totally Disabled but not for more than the maximum number of weeks shown on the Schedule. For any benefit provided for less than a week, We will pay one-seventh (1/7) of the Disability Benefit for each full day the Covered Person is Totally Disabled. The Waiting Period for this benefit begins on the date that the Sports Injury occurred and ends after the number of days have expired. We will not pay any benefits during the Waiting Period.]

## **SECTION 7: HAZARDS INSURED AGAINST**

We will pay benefits as shown in the Schedule of Benefits and described in the Policy when a Covered Person suffers a Covered Loss as a result of participation in a Covered Activity.

## **SECTION 8: EXCLUSIONS**

We will not pay benefits for any loss that is caused by, or results from:

- (1) [Suicide; self-destruction; attempted self-destruction while sane or insane; or intentionally self-inflicted Injury.]
- (2) [War or any act of war; declared or undeclared.]
- (3) [Service in the military or armed forces or units auxiliary thereto.]
- (4) [Illness, except as directly caused by and directly resulting from participation in a Covered Activity as provided by the Policy.]
- (5) [Mental or emotional disorders, except as specifically provided under the Post Traumatic Stress Disorder Benefit.]
- (6) [Alcoholism; drug addiction; or the use of any drug or narcotic except as prescribed by a Physician.]
- (7) [Injury that occurs while on board any type of aircraft while the aircraft is taking off, airborne, or landing. This exclusion does not apply to Injury to a Covered Person who is a passenger on an aircraft and is participating in a Covered Activity. However, no coverage is provided under any circumstances for Injury that occurs during or arising out of a planned parachute jump from an aircraft. Also, no coverage is provided if the Covered Person is the pilot or operator.]
- (8) [Any activity in football, ice hockey, field hockey, lacrosse, soccer, rugby and boxing.]
- (9) [Injury or Illness sustained by a Covered Person while operating, or riding as a passenger in, a motor vehicle if such Injury or Illness occurs as a direct result of the Intoxication of the Covered Person.]
- (10) [Under any Weekly Disability Benefit or Athletics and Special Events Benefit of the Policy, any loss caused by or resulting from Injury or Illness sustained by a registered Junior Member unless:
  - (a) such member is eligible for coverage under Workers Compensation, or other similar or comparable coverage; or
  - (b) such member has had full-time or part-time gainful employment during any part of the 12-month period immediately preceding the Injury or Illness, and the Average Weekly Wage

applying to such member exceeds \$1.00.]

## SECTION 9: CLAIM PROVISIONS

**Notice Of Claim:** A claimant must give Us or Our authorized representative written (or authorized electronic) notice of claim within 90 days after any Covered Loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person, the Covered Person's address, the Policyholder name, and the Policy Number.

**Claim Forms:** Upon receiving notice of a claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

**Proof Of Loss:** Written (or authorized electronic or telephonic) proof of loss must be sent to Us or Our authorized representative. Written (or authorized electronic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted if it is sent later than one year from the time proof is otherwise required.

For disability for which benefits may be payable for at least 2 years, the Covered Person must give Us notice of continuance of such disability, except in the event of legal incapacity. The notice must be given to Us every 6 months following the submission of the initial claim for benefits. The proof of loss will be considered a 6-month notice and notice will be required every 6 months thereafter. Delay in giving Us notice of a continuing disability will not affect the Covered Person's right to benefits otherwise accruing for the 6-month period before the date notice is actually given to Us.

The Covered Person is responsible for providing all necessary information to substantiate the validity of their claim.

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

**Time Payment Of Claims:** Any benefits due will be paid immediately after We receive written (or authorized electronic) proof of loss.

**Payment Of Claims:** We or Our authorized representative will pay a claim after receipt of acceptable proof of loss. If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the Covered Person's beneficiary. If no beneficiary is designated by the Covered Person, payment will be made to the first surviving class of the following classes:

1. Covered Person's spouse;
2. Covered Person's children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian);
3. Covered Person's mother or father, in equal shares;
4. Covered Person's brothers or sisters, in equal shares;

Otherwise, benefits will be paid to the Covered Person's estate.

All other benefits due are payable to the Covered Person. In the event the Covered Person is a minor, incompetent or otherwise unable to give a valid release for the claim, We may make arrangements to pay claims to the Covered Person's legal guardian, committee or other qualified representative.

We may pay medical expense benefits provided under the Policy directly to the provider rendering covered services, unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written proof of loss.

All payments made in good faith will discharge Our liability to the extent of the claim.

**Beneficiary:** The Covered Person may designate a beneficiary. The Covered person has the right to change the beneficiary at any time by written (or authorized electronic) notice. If the Covered Person is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective when it is received by the Policyholder. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Covered Person is the beneficiary for any Covered Dependent.

**Physical Examinations and Autopsy:** We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy. [Failure to submit to an examination two (2) consecutive times will result in termination of benefits, unless a reasonable explanation is provided or reasonable attempts to reschedule the examination are made.]

**Legal Actions:** No lawsuit or action in equity can be brought to recover on the Policy until there has been full compliance with all the terms of the Policy. All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No lawsuit or action in equity may be brought to recover on this Policy: (1) before sixty (60) days following the date proof of loss was given to Us; or (2) after three (3) years following the date proof of loss is required.

**Recovery of Overpayment or Error:** If benefits are overpaid, or paid in error, We will notify the Covered Person in writing of the circumstances surrounding the overpayment. Within sixty (60) days of receipt of the original notification, the Covered Person is required to repay Us the amount of overpayment.

Within thirty (30) days of receipt of the original notification, the Covered Person may request, in writing, additional information in regard to the overpayment. Your request to Us will not extend or modify the overpayment amount or time unless the Covered Person is notified by Us in writing.

We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods:

1. A request for lump sum payment of the amount overpaid, or paid in error;
2. Reduction of any proceeds payable under the Policy by the amount overpaid, or paid in error; or
3. Taking any other action available to Us.

**Right of Recovery:** A Covered Person may incur expenses due to an Injury or Sickness covered by the Policy. The loss may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of expense incurred charges. If recovery is made, the Covered Person must repay Us the Recovery made from: (a) the other person, or (b) the other person's insurer. We will only have such right against excess funds after the Covered Person is made whole.

Recovery means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for losses caused by the Injury or Sickness, less attorney's fees and court costs incurred in making the Recovery. This Right of Recovery provision also applies when a Covered Person receives payment under an uninsured or underinsured motorist insurance policy or plan.

**Other Coverage with Us:** If the Covered Person is covered under more than one similar Policy issued by Us, the total benefits payable will not exceed those payable under the Policy which provides the largest benefit.

**Facility of Payment:** A payment made under another plan may include an amount that should have been paid under this plan. If it does, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" means the reasonable cash value of the benefits provided in the form of services. "Payment made" includes providing benefits in the form of services.

**Exposure and Disappearance:** If, by reason of an accident, a Covered Person is unavoidably exposed to the elements and as the result of such exposure suffers a loss for which indemnity is otherwise payable, such loss will be covered under the terms of the Policy.

If the body of a Covered Person has not been found within one (1) year after the date of disappearance as the result of the sinking or wrecking of the aircraft or watercraft in which the Covered Person was riding at the time of the accident and under such circumstances as would otherwise be covered, it will be presumed that the Covered Person suffered loss of life resulting from Injury caused solely by a Covered Accident.

**Subrogation:** To the extent the Company pays for a loss suffered by a Covered Person, the Company will take over the rights and remedies the Covered Person had relating to the loss. This is known as subrogation. The Covered Person must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over an Covered Person's rights, the Covered Person must sign an appropriate subrogation form supplied by the Company. As permitted by law, the Company has the right to offset future benefits payable to the Covered Person under this Policy against any such Recovery.

#### SECTION 10: PREMIUM PROVISIONS

**Premiums:** The premiums for the Policy will be based on the rates currently in force, the plan, and amount of insurance and benefits in effect.

**Payment of Premium:** The first premium is due on the Policy Effective Date. After that, premiums will be due annually unless We agree with the Policyholder on some other method of premium payment. The Policyholder shall remit the premium to Us or Our authorized representative.

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

**Grace Period:** A Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

#### SECTION 11: GENERAL PROVISIONS

**Other Coverage With This Company:** If the Covered Person is covered under more than one similar policy issued by Us, the total benefits payable will not exceed those payable under the policy which provides the largest benefit.

**Entire Contract; Changes:** The Policy (including any endorsements or amendments), and the signed application of the Policyholder are the entire contract. Any statements made by the Policyholder or Covered Persons will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application and a copy is provided to the person who made such statement (or their beneficiary or representative).

To be valid, any change or waiver must be in writing. It must be signed by our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

**Policy Effective Date And Termination Date:** The Policy begins on the Policy Effective Date at 12:01 AM Standard Time at the address of the Policyholder where the Policy is delivered. Either We or the Policyholder may terminate the Policy on any Premium Due Date by giving 31 days advance written notice to the other party. The Policy may be terminated at any time by mutual written consent of the Policyholder and Us. The Policy terminates automatically on the earlier of: 1) the end of the Policy Term shown in the Schedule of Benefits; or 2) the Premium due date if Premiums are not paid when due, subject to the Grace Period. Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

**Clerical Error:** If a clerical error is made, whether by the Policyholder or by Us, it will not invalidate coverage otherwise validly in effect; nor continue coverage otherwise validly terminated, provided such

clerical error is not prejudicial to Us and is rectified promptly upon discovery. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

**Data Required:** The Policyholder shall furnish Us with all information that We may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder in connection with the insurance, together with such records, as may have a bearing on the insurance under the Policy, shall be open for inspection by Us at all reasonable times.

**Examination Of Records And Audit:** We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after the termination of the Policy as they relate to the premiums or subject matter of this insurance.

**Certificates Of Insurance:** Where it is required by law, or upon the request of the Policyholder, We will make available to all Covered Persons certificates outlining the benefits of this Policy.

**Conformity With State Laws:** On the effective date of the Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

**Not In Lieu Of Workers' Compensation:** The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits and does not satisfy any requirements for coverage by any Workers' Compensation Act or similar law.

**New Entrants:** New eligible persons added from time to time to the Policyholder group will automatically be covered under the Policy.

**Assignment:** This Policy is not assignable, whether by operation of law or otherwise. Benefits may be assigned. No assignment of interest in loss of life benefits shall be binding on Us until the original or duplicate thereof is received by Us. We assume no responsibility for the validity of such assignment.

**Insolvency:** The insolvency; bankruptcy; financial impairment; receivership; voluntary plan of arrangement with creditors; or dissolution of the Policyholder will not impose upon Us any liability other than the liability defined in this Policy. The insolvency of the Policyholder will not make Us liable to the creditors of the Policyholder, including Covered Persons under the Plan.

**Incontestability:** Except for nonpayment of premiums, We will not contest the validity of the Policy after it has been in force for two years from its date of issue.

**Misrepresentation or Fraud:** This entire Policy will be void, whether before or after a loss, if We determine that the Policyholder; Covered Person; or its agent has concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim or any case of fraud by the Policyholder; Covered Person; Third Party Administrator; or other agent relating to this Policy.

**Waiver:** Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.



**ARCH INSURANCE COMPANY**  
(A Missouri Corporation)

Home Office Address:  
3100 Broadway, Suite 511  
Kansas City, MO 64111

Administrative Address:  
One Liberty Plaza, 53rd Floor  
New York, NY 10006  
Tel: (800) 817-3252

**BLANKET INSURANCE CERTIFICATE**

**POLICYHOLDER:** ABC

**POLICY NUMBER:** 12345

**POLICY EFFECTIVE DATE:** January 1, 2010

**POLICY ANNIVERSARY DATE:** January 1

**POLICY TERM:** January 1, 2010 – January, 2011

**STATE OF DELIVERY:** Connecticut

This Certificate of Insurance is issued under the terms of the Policy issued to the Policyholder. Coverage is only described in the Certificate of Insurance. It is not the insurance contract. The Policy is the only contract under which benefits are paid. The Policy may be examined, upon request, at the office of the Policyholder.

We insure each person in one of the Classes of Eligible persons provided the required premium is paid when due. We will pay the benefits described in the Policy for certain losses resulting directly, and independently of all other causes, from an accident or accidental bodily injuries that:

1. occur while the Policy is in force and Your coverage is in effect; and
2. arise out of participation in a Covered Activity and Hazard described in the Policy; subject to all the provisions, conditions, exclusions and limitations of the Policy.

IN WITNESS WHEREOF, Arch Insurance Company has caused this certificate to be executed and attested.

Handwritten signature of Martin J. Nilsen in cursive.

\_\_\_\_\_  
Martin J. Nilsen  
Secretary

Handwritten signature of Mark D. Lyons in cursive.

\_\_\_\_\_  
Mark D. Lyons  
President

**THIS IS A CERTIFICATE FOR BLANKET INSURANCE  
LIMITED BENEFITS: THE POLICY PAYS BENEFITS FOR SPECIFIC LOSSES DURING THE  
HAZARDS SHOWN IN THE SCHEDULE OF BENEFITS ONLY.  
PLEASE READ THE POLICY CAREFULLY.**

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**SECTION 1: SCHEDULE OF BENEFITS**

**POLICYHOLDER NAME:**

**POLICYHOLDER ADDRESS:**

**POLICY NUMBER:**

**POLICY EFFECTIVE DATE:**

**POLICY ANNIVERSARY DATE:**

**POLICY TERM:**

**PREMIUM DUE DATE:** Annually in advance on Anniversary Date

**CLASSES OF ELIGIBLE PERSONS:**

The Policy provides coverage for the following class(es) of Covered Person(s) only:

[For the Municipality stated as the Policyholder, coverage under this Policy is limited to the indicated Classes of Eligible Persons of {list applicable fire, emergency, rescue or ambulance department}.]

Class 1 Volunteers]

[Any officially designated member in good standing of the Policyholder, including 1) Volunteer members or volunteer members who receive nominal fees as retainers; 2) registered junior members; 3) any director, commissioner, trustee, board member, officer of the board, or holder of a similar position; 4) part time employees of the Policyholder with no more than 1,300 hours annually; and 5) any bystander deputized by an official of the Policyholder at the scene of an emergency to assist at the emergency, but only until the emergency ends. Eligibility does not include a paid employee of the Policyholder who works more than 1,300 hours annually for the Policyholder and who is acting within the scope of his or her employment.]

Class 2 Auxiliary]

[A member of the Policyholder’s auxiliary organization by whatever name called and 1) any person while assisting the auxiliary organization if requested to do so by an officially designated member in good standing of the Policyholder or the Policyholder’s auxiliary organization and 2) any person while assisting the Policyholder if requested to do so by an officially designated member in good standing of the Policyholder.]

Class 3 Career Personnel]

[A paid employee of the Policyholder who works more than 1,300 hours for the Policyholder and who is acting within the scope of his or her employment.]

**HOW BENEFITS ARE PAID**

If **“Primary”**, **We** will pay covered medical expenses incurred by a Covered Person on a primary basis without regard to benefits that may be paid or payable under Workers’ Compensation or any Other Valid and Collectible Insurance.]

If **“Excess”**, **We** will not pay covered medical expenses incurred by a Covered Person that are paid or payable under Workers’ Compensation or any Other Valid and Collectible Insurance.]

**ANNUAL PREMIUM: \$**

**SCHEDULE OF BENEFITS (continued)**

PART	BENEFIT	AMOUNT OF INSURANCE	CLASSES OF ELIGIBLE PERSONS		
			1	2	3
<b>I</b>	<b>Indemnity Benefits</b>				
	A. Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Illness Loss of Life Benefit	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Seat Belt Benefit	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D. Post Traumatic Stress Disorder Benefit – Per Person, Per Covered Activity	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>II</b>	<b>Permanent Physical Impairment Benefit – Injury Only</b>	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>III</b>	<b>Permanent Physical Impairment Benefit – Illness Only</b>	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IV</b>	<b>Weekly Disability Permanent Physical Impairment Benefit – Injury Only</b>	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>V</b>	<b>Cosmetic Burn Disfigurement Benefit – Injury Only</b>	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VI</b>	<b>Permanent Cardiac Impairment Benefit – Illness Only</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VII</b>	<b>Medical Expense Benefit – Injury Only</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	A. Medical Expenses	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Additional for Plastic Surgery Expenses	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VIII</b>	<b>Medical Expense Benefit – Illness Only</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	A. Medical Expenses	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Preventative Inoculations	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IX</b>	<b>Weekly Disability Benefit – Injury Only</b>				
	A. Total Disability	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Partial Disability	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>X</b>	<b>Weekly Disability Benefit – Illness Only</b>				
	A. Total Disability	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Partial Disability	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XI</b>	<b>Family Expense Benefit – Injury or Illness</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XII</b>	<b>Family Education Benefit – Injury or Illness</b>				
	A. Dependent Child	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Surviving Spouse or Domestic Partner	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Other	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XIII</b>	<b>Athletic and Special Events Benefit – Injury Only</b>				
	A. Medical Expense	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Total Disability	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XIV</b>	<b>HIV Benefit</b>				
	A. HIV Lump Sum	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. HIV Infection Prevention	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XV</b>	<b>Physical Assault Benefit – Injury Only</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XVI</b>	<b>Day Care Expense Benefit – Injury or Illness (up to a maximum of 26 weeks)</b>	<b>Household Maximum (per Day) \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XVII</b>	<b>Permanent Physical Impairment Education Benefit – Injury Only</b>	<b>35% of Permanent Physical Impairment Benefit – Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>XVIII</b>	<b>Residence and Vehicle Adaptation Expense Benefit</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SCHEDULE OF BENEFITS (continued)**

PART	BENEFIT	AMOUNT OF INSURANCE	CLASSES OF ELIGIBLE PERSONS		
			1	2	3
XIX	<b>Continuation of Coverage Benefit – Injury Only</b>	<b>Per Month \$ Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XX	<b>Accidental Death and Dismemberment – Injury Only</b>	<b>24 Hour Coverage <input type="checkbox"/> Off-Duty Coverage <input type="checkbox"/></b>			
	A. Loss of Life	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Dismemberment Loss	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Loss of Life – Military Duty	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXI	<b>Burial and Cremation Benefit</b>	<b>10% of Principal Sum – Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXII	<b>Survivor Benefits</b>				
	A. Child	<b>10% of Principal Sum – Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B. Surviving Spouse or Domestic Partner	<b>10% of Principal Sum – Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C. Elder	<b>10% of Principal Sum – Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXIII	<b>Transition Benefit</b>	<b>Maximum \$ Maximum Number of Weeks</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXIV	<b>Critical/Traumatic Incident Stress Management Team</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXV	<b>Emergency Medical Evacuation and Repatriation Benefit</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXVI	<b>Repatriation Benefit</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
XXVII	<b>Optional Benefits</b>				
	<b>A. Additional Weekly Disability Benefit – 1<sup>st</sup> Week of Total Disability</b>	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>B. Weekly Hospital Indemnity Benefit</b>	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>C. Auxiliary Member Benefits – Injury Only</b>				
	1. Indemnity Benefits	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Medical Expense	<b>Maximum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Weekly Disability	<b>Weekly Benefit \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>D. Organized League Sports Benefit*</b>				
	1. Accidental Death, Dismemberment, Loss of Sight, Speech, or Hearing	<b>Principal Sum \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Medical Expense	<b>Maximum \$ Deductible \$</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Weekly Disability	<b>Weekly Benefit \$ Waiting Period Maximum Number of Weeks</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	*Sports Teams Covered:				

## SECTION 2: DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

**Accident** - means a sudden, unexpected and unintended event that results in Injury to the Covered Person.

**Athletic Games, Contests or Special Events** - means any athletic game, contest or special event that: (1) the Policyholder has organized, sanctioned or approved of; and (2) is not part of a regularly scheduled activity of an organized league, nor sponsored by an organized league. However, Athletic Games, Contests or Special Events does not include football (tackle, touch or flag), ice hockey, field hockey, lacrosse, soccer, wrestling, rugby or boxing.

**Average Weekly Wage** – means the Covered Person’s average personal income per week based upon the greater of the following: 1) the amount shown for “wages, salaries, tips, etc.” on the Covered Person’s U.S. Individual Income Tax Return for the calendar year immediately preceding the year in which the loss occurred; 2) the wages or income earned by the Covered Person in the 12 months immediately preceding the loss; 3) the wages or income earned by the Covered Person in the 3 months preceding the loss; or 4) if self-employed, the amount shown as Business Income (Schedule C), Supplemental Income (Schedule E), and/or Farm Income (Schedule F), excluding rental income, investment income, or other passive income, on the Covered Person’s U.S. Individual Income Tax Return for the calendar year immediately preceding the year in which the loss occurred.

**Cardiac Malfunction** – means a sudden and serious malfunction of the heart or circulatory system caused by and directly resulting from participation in a Covered Activity while coverage is in force under the Policy. Such malfunctions shall include those commonly diagnosed as myocardial infarction, cardiac arrest, coronary thrombosis and cerebral vascular accident (e.g. stroke or aneurysm.) Cardiac Malfunction does not include conditions such as hypertension or angina.

**Covered Activity** – means participation in, including travel directly to and from, any activity that is: (1) a normal duty of an Covered Person for the Policyholder; and (2) performed at the direction or with the knowledge of an officer of the Policyholder, or (3) at the scene of an emergency requiring immediate action not on behalf of the Policyholder. Such activity includes but is not limited to: (1) fire suppression or an emergency response; (2) rescue or emergency medical activity; (3) training exercise; (4) fund raising including athletic activities, however, covered athletic activities are limited to those performed for the sole purpose of fund-raising for the Policyholder; (5) a drill, parade, conference, convention, meeting, or dinner; or (6) a Firematic Event or Contest, or other competitive or non-competitive training school or program.

**Covered Loss(es)** - means an accidental death, dismemberment or other Injury or Illness covered under the Policy.

**Covered Person** – means an eligible person who is within the covered class(es) listed in the Policy and for whom the required premium is paid when due.

**Critical Incident Stress Management Team (CISMT)** – means a formally organized group of mental health professionals and peer support individuals trained to provide support services to emergency service personnel. Such support services include stress debriefing, defusing, demobilization, stress education, spousal support, one-on-one interviews, or on the scene support.

**Day Care Expense** - means the reasonable and customary cost of providing regular daily supervision or nursing services for a member of the Covered Person’s Immediate Family if such family member is a child age 12 years or younger or such person is mentally or physically disabled or infirmed and would reasonably require such care. Day Care Expense does not include the cost of any care provided by a Covered Person or an Immediate Family Member, nor by any individual or organization that is not duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received.

**Deductible** - means the dollar amount of covered expenses that must be incurred by the Covered Person as an out-of-pocket expense on a per Accident basis before Medical Expense Benefits and/or other Additional Benefits paid on an expense incurred basis are payable under the Policy.

**Dependent Child** - means an unmarried child who is dependent upon the Covered Person as of the date of the Covered Person's death for at least 50% of his or her support and maintenance.

**Domestic Partner** - means an opposite or same sex partner who, for at least 12 consecutive months, has resided with the Covered Person and shared financial assets/obligations with the Covered Person. Both the Covered Person and the Domestic Partner must: (1) intend to be life partners; (2) be at least the age of consent in the state in which they reside; and (3) be mentally competent to contract. Neither the Covered Person nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

**Firematic Events or Contests** – means practice or participation in an organized event intended to enhance the Covered Person's skills or emergency reaction times. These events include, but are not limited to, departmental or interdepartmental: (1) apparatus pumping contests; (2) battle of the barrel; (3) antique pumping; (4) hose rolling contests; (5) equipment donning contests; (6) bucket brigades; (7) ladder climbs; (8) tug of war contests; and (9) apparatus operation rodeos.

**Home Health Care** - means those nursing and other home health care services provided to a Covered Person in his or her place of residence. Home Health Care must be: (1) performed by a Home Health Care Practitioner; (2) in lieu of confinement in a Hospital or nursing facility, and (3) pursuant to the orders of the attending Physician. Such attending Physician's orders must be written and include a plan of care which must be reviewed and approved by the Physician on an ongoing basis.

**Home Health Care Practitioner** - means a nurse, medical social worker, home health aide, physical therapist, or other medical practitioner. However, no provider will be considered a Home Health Care Practitioner unless such practitioner is: (1) duly licensed and/or certified in compliance with all applicable laws and regulations to provide the care received, and (2) not a Covered Person or an Immediate Family Member.

**Hospital** - means an institution that: (1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons, and is a duly licensed institution, operated lawfully in its area; (2) provides 24-hour nursing service by registered nurses on duty or call; (3) has a staff of one or more licensed Physicians available at all times; (4) provides organized facilities for diagnosis, treatment and surgery, either a) on its premises; or b) in facilities available to it, on a pre-arranged basis; (5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and (6) is not a facility for the treatment of drug addiction, alcoholism, treatment of the aged.

We will not deny a claim for services rendered in a Hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability: (1) the Joint Commission of Accreditation of Hospitals; or (2) the American Osteopathic Association; or (3) the Commission on the Accreditation of Rehabilitative Facilities.

**Illness** - means any disease, illness, or infection caused by or resulting directly from the Covered Person's participation in a Covered Activity. Illness includes Cardiac Malfunction. Illness does not include Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or any AIDS related disease, illness, infection, or debility.

**Immediate Family Member** - means the Covered Person's parent, grandparent, spouse, child(ren) (includes legally adopted), step child(ren), brother, sister, grandchild(ren), in-laws or any person living at the time of loss in the Covered Person's household.

**Injury** - means accidental bodily Injury sustained by the Covered Person: (1) during and resulting from a Covered Person's participation in a specific Covered Activity while coverage under the Policy is in force as to the Covered Person; and (2) which directly (independent of Illness, disease, mental incapacity or

any other cause) causes a loss to the Covered Person; Injury does not include: (1) Illness; (2) Cardiac Malfunction; nor (3) Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or any AIDS-related disease, illness, infection, or debility.

**Institution of Higher Learning** - includes but is not limited to, any state university, private college, professional or trade school.

**Intoxication** - means the Covered Person is intoxicated by the use of alcohol or the illegal use of drugs as defined by the applicable state Motor Vehicle statutes in the state where the Injury occurred.

**Left Ventricular Ejection Fraction** - means a clinically used measure of the function of the left ventricle. The ejection fraction is the percentage of blood ejected from the left ventricle with each heart beat.

**Maximum Medical Improvement** - means the point where a Covered Person's condition will no longer improve by treatment or time.

**New York Heart Association (NYHA) Functional Classification** - means a four category classification system used to assess the stage or extent of heart failure. The system relates symptoms to everyday activities and the patient's quality of life. A summary of the four categories is as follows:

Class I No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or shortness of breath.

Class II Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or shortness of breath.

Class III Marked limitation of physical activity. Comfortable at rest, but less than ordinary physical activity results in fatigue, palpitation, or shortness of breath.

Class IV Unable to carry out any physical activity without discomfort. If any physical activity is undertaken, discomfort is increased.

**Other Valid and Collectible Insurance** - means any: 1) group plan, program, or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans or group employer or employee benefit programs; or (4) any no-fault automobile insurance plan or similar law. Other Valid and Collectible Insurance will not include benefits provided by the United States Social Security Act or any individual disability insurance plans.

**Partial Disability, Partially Disabled** - means a Covered Person's inability to do one or more, but not all, of the material and substantial duties of his or her Regular Occupation. The Covered Person must be under the regular care of a Physician during Partial Disability.

**Period of Eligibility** - means a period of time from the date the Covered Person receives notice from Us by certified mail of the right to claim a benefit under the Weekly Disability Permanent Physical Impairment Benefit to: (1) [90] days after receipt of notice from Us, or (2) [260] weeks from the date of the Injury that caused the Permanent Physical Impairment, whichever is sooner.

**Permanent Cardiac Impairment** - means a medical condition causing an abnormality of, partial loss of, or loss of function of the heart resulting in: 1) a Left Ventricular Ejection Fraction of [30%] or less; and 2) a New York Heart Association Functional Classification of II, III, or IV.

**Permanent Physical Impairment** - means a medical condition that is a physical or functional abnormality or loss, that remains after Maximum Medical Improvement has been achieved, and that is considered stable or non-progressive by the Physician at the time an evaluation is made.

**Physical Assault** - means a physical Injury as a result of a deliberate and offensive act directed towards the Covered Person that creates a substantial risk of death, or that causes death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ.

**Physician** - means a person who is a qualified doctor of medicine or dental practitioner. As such, he or she must be acting within the scope of his or her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his or her license or certificate. Physician includes a physician's assistant or nurse practitioner. Physician does not include the Covered Person, Immediate Family Member, a physical therapist, or an intern.

**Policy** - means the contract issued to the Policyholder named in the Policy application.

**Policy Term** - means the period of time a Policyholder group is covered by the Policy. The Policy Term is shown in the Schedule of Benefits.

**Policyholder** - means a [non-profit emergency service organization] [or Municipality] that elects coverage under the Policy and pays the required premium. Coverage under the Policy for a Policyholder group will become effective on the Policy Effective Date shown in the Schedule of Benefits, subject to the payment of the required premium.

**Post Traumatic Stress Disorder** - means (1) recurrent and intrusive distressing recollections of the traumatic event; (2) recurrent distressing dreams of the traumatic event; (3) suddenly acting or feeling the traumatic event is recurring; or (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event.

**Reasonable and Customary Expense** - means an expense that: (1) is charged for treatment, supplies or medical services medically necessary to treat the Covered Person's condition; (2) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

**Regular Occupation** - means the full or part-time gainful employment of the Covered Person at the time of Injury or Illness. Should the Covered Person not be gainfully employed at the time of Injury or Illness, Regular Occupation means the Covered Person's normal lifestyle he could engage in at the time of Injury or Illness. Regular Occupation in no way relates to the Covered Person's duties or responsibilities as a volunteer for the Policyholder.

**Residence and Vehicle Adaptation Expenses** - means one-time expenses incurred by or paid on behalf of the Covered Person for (1) adaptation of the Covered Person's residence to make it accessible to and/or habitable by the Covered Person; and (2) adaptation of the Covered Person's vehicle to make it accessible to and/or drivable by the Covered Person. The adaptations must be (1) made by an individual experienced in such adaptations; and (2) in compliance with any applicable laws of or requirements for approval by local, state or federal government authorities.

**Schedule** - means the Schedule of Benefits which is part of the Policy, Certificate or summary of coverage.

**Sports Injury** - means accidental bodily Injury sustained during and directly resulting from an organized game or practice of a Sports Team, or while traveling directly to or from such game or practice that directly and independently causes a loss to the Covered Person. Sports Injury does not include: (1) Illness; (2) Cardiac Malfunction; nor (3) bodily Injury triggered by or related to any known or previously diagnosed pre-existing heart or circulatory condition.

**Sports Team** - means a team officially recognized, sponsored, authorized, or supervised by the Policyholder, provided that it is a part of, or competes under the sponsorship of, an established amateur athletic league, by whatever name called.

**Surviving Spouse** - means the legal spouse of the Covered Person as of the date of the Covered Person's death according to the laws of the state in which the Covered Person resides on the date of death.

**Total Disability, Totally Disabled** - means a Covered Person's inability to perform the material and substantial duties of his or her Regular Occupation. After 5 years from the date of Injury or Illness, Total Disability and Totally Disabled means the Covered Person's inability to perform the material and substantial duties of any occupation for which the Covered Person is reasonably suited based on education and experience. The Covered Person must be under the regular care of a Physician during Total Disability.

**We, Our, Us** - means the Insurance Company underwriting this insurance.

### **SECTION 3: ELIGIBILITY FOR INSURANCE**

If the Covered Person is in one of the Classes of Eligible Persons shown in the Schedule of Benefits, he or she is eligible to be insured on the Policy Effective Date. New eligible persons added from time to time to the Policyholder group will automatically be covered under the Policy if premium is paid for such persons.

A Covered Person's Dependent is eligible on the date:

1. the Covered Person is eligible, if the Covered Person has Dependents on that date; or
2. the date the person becomes a Dependent, if later.

If the Covered Person is in a Class of Eligible Persons and is also eligible as a Dependent, he or she may be Covered only once under this Blanket Policy. In no event will a Dependent be eligible if the Covered Person is not eligible.

### **SECTION 4: EFFECTIVE DATE OF INSURANCE**

A Covered Person will be insured on the latest of the following dates:

1. the Policy Effective Date; or
2. the date he or she is eligible.

A Dependent's insurance will not be in effect prior to the date a Covered Person is insured.

### **SECTION 5: TERMINATION DATE OF INSURANCE**

A Covered Person's coverage will end on the earlier of the date:

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

A Dependent's coverage will end on the earlier of the date:

1. he or she is no longer a Dependent;
2. the Covered Person's coverage ends;
3. the period ends for which premium is paid.

**SECTION 6: DESCRIPTION OF BENEFITS**

The following Provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits.

**PART I – INDEMNITY BENEFITS**

If Indemnity Benefits coverage is selected on the **Schedule**, We will pay the Benefit as shown below.

**[A. Accidental Death & Dismemberment, Loss of Sight, Speech or Hearing – Injury Only**

If Injury to a Covered Person results in any one of the losses listed below, we will pay the benefit shown for that loss. If the Covered Person suffers more than one loss as a result of any one accident, only the largest amount will be paid.

<b>For Loss of:</b>	<b>% of Principal Sum</b>
[Life	100%
Both Arms or Both Legs	100%
Both Hands and Both Feet	100%
One Arm and One Leg	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
Hearing	50%
Speech	50%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Permanent Damage to Sight of One Eye – up to Maximum Benefit of*	50%
One Thumb	10%
One Hallux (big toe)	10%
One Finger	5%
One Toe	5%
Each Joint of Thumb or Hallux	5%
Each Joint of Finger or Toe	1%
*See Vision Impairment Schedule below]	

**Loss** means, with reference to the hand or foot, a complete severance through or above the wrist or ankle joint; with reference to the arm or leg, the complete severance through or above the elbow or knee joint; with reference to the fingers and thumb, the complete severance at the metacarpophalangeal joint; with reference to the hallux and toes, the complete severance through the metatarsal phalangeal joint; and with reference to a joint of a finger or toe, the complete severance of a distal, proximal or (if applicable) medial phalanx. Loss of sight, speech or hearing means the total and irrecoverable loss of sight, speech or hearing.

**Permanent Damage** means, with reference to sight, irreparable Injury that results in permanently impaired vision, but not in total and irrecoverable loss of vision. The following lists the amount payable for the degree of vision impairment due to Permanent Damage. The benefit paid for each eye will not be more than one half the Principal Sum. If the sight of an eye is less than 20/20 before the Permanent Damage, We will pay a benefit based upon the additional impairment due to the covered Injury. The amount shown in the Table applies separately to each eye.

<b>Vision Impairment Schedule</b>	<b>% of Principal Sum Payable for Each Eye</b>
20/20	0.0%
20/30	2.75%
20/40	5.5%
20/50	8.25%
20/60	11.0%
20/80	16.5%
20/100	22.0%
20/120	28.0%
20/150	36.0%
20/180	44.5%
20/200 or poorer	50.0%

If the Covered Person suffers more than one Covered Loss as a result of any one accident, multiple benefits under this benefit will be paid to the extent that one benefit does not duplicate another benefit. For example, if a Covered Person loses an arm in an accident, We will pay for “Loss of Arm” but not for “Loss of Hand,” “Loss of Thumb,” nor “Loss of Finger Joints.”

If the Covered Person loses an arm and, in the same accident, is blinded in one eye, We will pay for both the “Loss of Arm” and the “Loss of Entire Sight in One Eye”. However, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[B. Additional Loss of Life Benefit – Illness Only**

If a loss of life benefit is not payable under “A” We will pay the amount shown in the Schedule if death occurs due to Illness which is a direct result of participation in a Covered Activity; and

- (1) death occurs within 180 days of the date the Covered Person participated in the Covered Activity that caused such loss; or
- (2) a Physician or Hospital provided medical treatment to the Covered Person for such Illness within 90 days of the date the Covered Person participated in the Covered Activity that caused such loss.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[C. Additional Seat Belt Benefit – Injury Only**

If the loss of life benefit is payable under “A”, We will pay an additional 25% of the Principal Sum if the Covered Person was in a motor vehicle and wearing a properly fastened seat belt when the Injury occurred that caused death.]

**[D. Post-traumatic Stress Disorder Benefit**

If the Covered Person suffers from a Post-traumatic Stress Disorder directly caused by an event during a specific single Covered Activity, We will pay the Reasonable and Customary Expenses incurred for inpatient or outpatient treatment up to the Maximum Limit in the Schedule. The event causing the Post-traumatic Stress Disorder must be witnessed during a Covered Activity that is outside the range of usual human experiences and would be markedly distressing to almost anyone, such as:

- (1) actual or threatened serious physical harm to the Covered Person’s life or body;
- (2) witnessing actual or threatened serious physical harm to the life or body of other Covered Persons;
- (3) witnessing another person who has recently been or is being seriously injured or killed as a result of an accident or physical violence.]

**[PART II – PERMANENT PHYSICAL IMPAIRMENT BENEFIT – INJURY ONLY**

If Permanent Physical Impairment Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results in Permanent Physical Impairment, We will pay this benefit only if the Covered Person:

- (1) is Totally Disabled or Partially Disabled as a result of such Injury; and
- (2) has participated in an approved physical rehabilitation program, if the physical condition so warrants, and has reached their Maximum Medical Improvement.

The examining Physician must certify that the Covered Person is suffering from a Permanent Physical Impairment, and has reached their Maximum Medical Improvement.

Permanent Physical Impairment will be assigned an impairment value by an examining Physician. This value will be expressed as a percentage in relation to the whole person. The impairment value will be determined by the most current edition of the American Medical Association’s *Guides to the Evaluation of*

*Permanent Impairment.* (In the event the referenced guide ceases to be published, We will use another appropriate measurement of impairment values.) This percentage value will be applied to the benefit shown in the Schedule to determine the amount payable under the Policy. If the Covered Person has a prior physical impairment, the impairment value that represents the prior physical impairment will be deducted from the Permanent Physical Impairment evaluation.

If the Covered Person has an impairment value of 90% or higher, we will pay 125% of the Permanent Physical Impairment Benefit – Injury Only principal sum shown in the Schedule.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 125% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

### **[PART III – PERMANENT PHYSICAL IMPAIRMENT BENEFIT – ILLNESS ONLY**

If Permanent Physical Impairment Benefit – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

The Permanent Physical Impairment Benefit – Illness Only shown in the Schedule is payable if Illness to a Covered Person results in 5 years (260 weeks) of Total Disability Benefits.

#### **The benefit is payable as follows:**

- (1) [If the Covered Person is unable to return to his or her Regular Occupation after 5 years (260 weeks) of receiving Total Disability Benefits, 50% of the Permanent Physical Impairment Benefit – Illness Only principal sum shown in the Schedule is payable.]
- (2) [If the Covered Person is unable to return to any occupation after 5 years (260 weeks) of receiving Total Disability Benefits, 75% of the Permanent Physical Impairment Benefit – Illness Only principal sum shown in the Schedule is payable.]
- (3) [If, after 5 years (260 weeks) of receiving Total Disability Benefits, the Covered Person has been approved for Social Security disability benefits or, if not eligible for Social Security disability benefits, otherwise meets the eligibility criteria for Social Security disability benefits, 125% of the Permanent Physical Impairment Benefit – Illness Only principal sum shown in the Schedule is payable.]

The five year (260 week) period of Total Disability must be payable as a result of one Illness sustained while participating in the same Covered Activity.

If a Covered Person has received a Permanent Cardiac Impairment Benefit and later becomes eligible for payment under this benefit for the same condition, the amount payable under this benefit is the Permanent Physical Impairment Benefit – Illness Only amount shown in the Schedule, less the amount previously paid under the Permanent Cardiac Impairment Benefit – Illness Only. The percentage schedule as described in the second paragraph of this Part III will also apply to the total amount payable.

If the Covered Person receives this benefit, any right to collect benefits under any Weekly Disability Benefit of the Policy will end with the payment of this benefit.]

### **[PART IV – WEEKLY DISABILITY PERMANENT PHYSICAL IMPAIRMENT BENEFIT – INJURY ONLY**

If Weekly Disability Permanent Physical Impairment Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results in a Permanent Physical Impairment and it is determined that the Covered Person has a whole person Permanent Physical Impairment due to an Injury, we will pay the Weekly Disability Permanent Physical Impairment Benefit – Injury Only as shown in the Schedule. A whole person Permanent Physical Impairment due to an Injury means the percentage value of 50% or greater for purposes of the Weekly Disability Permanent Physical Impairment Benefit.

The Covered Person must elect to accept this weekly disability benefit and notify Us of such election by registered mail within the Period of Eligibility. If no election is made within the Period of Eligibility, We will notify the Covered Person and the Period of Eligibility will be extended an additional 90 days. If the Covered Person does not notify Us by registered mail of the election to accept the payment under this

benefit prior to the expiration of the 90-day extension period, the Covered Person will lose the right to claim this benefit.

However, under no circumstances will We pay a benefit under this Part IV if We are notified of the Covered Person's election to accept the benefit more than 5 years (260 weeks) after the date of the Injury that caused the Permanent Physical Impairment, even if such notification is received during the Period of Eligibility or the 90-day extension period described above.

This Weekly Disability Permanent Physical Impairment Benefit will be paid for the remainder of the Covered Person's lifetime.

The Weekly Disability Permanent Physical Impairment Benefit will be determined by multiplying the Weekly Disability Benefit - Injury only amount payable on the 29th day of Total Disability, as determined under Part IX of the Policy, by the percentage value of the Covered Person's Permanent Physical Impairment.

The Permanent Physical Impairment rating due to an Injury used to determine the Weekly Disability Permanent Physical Impairment Benefit is final upon initiation of Weekly Disability Permanent Physical Impairment Benefits. Subsequent changes in the Injury Rating of the Permanent Physical Impairment, if any, will not affect the Weekly Benefits paid or payable under this Part IV.

The benefit payable under this Part IV will be paid in addition to any benefits paid or payable under the Policy, except those paid or payable under Part IX.]

**[PART V – COSMETIC BURN DISFIGUREMENT BENEFIT – INJURY ONLY**

If Cosmetic Burn Disfigurement Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person suffers from disfigurement due to a burn that is classified as a third or fourth degree burn as the result of an Injury, We will pay this benefit.

All benefits payable are based on a percentage of the Principal Sum shown in the Schedule for this benefit and depend on the area of the body that was burned. Each body part is assigned a percentage relative to its visual exposure. The benefit payable for any one loss is determined by multiplying the percentage of body surface actually burned times the maximum percentage of the Principal Sum payable. The attending Physician will determine the percentage applicable to each burn. The list below shows the maximum percentage of the Principal Sum, by body part.

<b>Body Part</b>	<b>% of Principal Sum</b>
Face, Neck, Head	100%
Torso (Front)	35%
Torso (Back)	35%
Hand & Forearm (Right)	25%
Hand & Forearm (Left)	25%
Upper Arm (Right)	15%
Upper Arm (Left)	15%
Thigh (Right)	10%
Thigh (Left)	10%
Lower Leg (Right, below knee)	10%
Lower Leg (Left, below knee)	10%

For example, by using the Burn Disfigurement Schedule above:

- (1) if the entire surface of the hand and forearm were burned the benefit would be 25% of the Principal Sum; or
- (2) if 50% of surface of the hand and forearm were burned the benefit would be 50% of 25%, or 12.5% of the Principal Sum.

The above list only represents the maximum percentage of the Principal Sum payable for any one Covered Loss. If the Covered Person suffers burns in more than one area as a result of any one accident, the total of benefits for all such burns will not exceed 100% of the Principal Sum.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[PART VI – PERMANENT CARDIAC IMPAIRMENT BENEFIT – ILLNESS ONLY**

If Permanent Cardiac Impairment Benefit – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If the Covered Person suffers a Permanent Cardiac Impairment (PCI) as a result of a heart condition, We will pay a percentage of the Principal Sum shown in the Schedule if:

- (1) the heart condition was sustained as a result of a Covered Activity; and
- (2) it resulted in at least [26] weeks of Total Disability; and
- (3) the Covered Person had a Left Ventricular Ejection Fraction greater than [35%] prior to the date of the Covered Activity.

The Covered Person’s highest Left Ventricular Ejection Fraction (LVEF) and lowest New York Heart Association (NYHA) Functional Classification ratings will be obtained not more than 12 months after the Covered Activity that caused the heart condition. The ratings must have been determined following the date of the Covered Activity. The ratings will be used to determine the base benefit amount from the PCI Chart below.

**PCI Chart**

<b>[LVEF</b>	<b>NYHA Functional Class</b>	<b>% of Principal Sum</b>
< 21% Function	IV	100%
< 21% Function	II or III	75%
21 – 25% Function	IV	75%
21 – 25% Function	II or III	50%
26 – 30% Function	IV	50%
26 – 30% Function	II or III	25%]

The base benefit amount will then be adjusted based on the Covered Person’s age on the date of the Covered Activity that caused the heart condition using the Age Adjustment Chart below.

**Age Adjustment Chart**

<b>[Covered Person’s Age</b>	<b>Benefit Due %</b>
40 or younger	125% of Base Benefit
41 – 65	75% of Base Benefit
66 or older	50% of Base Benefit]

The benefit due is calculated by multiplying the Principal Sum by the % of Principal Sum in the PCI Chart by the Benefit Due % in the Age Adjustment Chart. For Example: A 35 year old with a LVEF of 24% and a NYHA Functional Class of III would be due 62.5% if the Principal Sum.

In the event benefits are payable under this benefit and any other benefit paying a Principal Sum as a result of any one accident, the total amount We will pay will not exceed 100% of the Principal Sum shown in the Schedule for only one benefit, the Principal Sum that is the largest.]

**[PART VII – MEDICAL EXPENSE BENEFIT – INJURY ONLY**

If Medical Expense Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Medical Expenses** – If, as the result of Injury, a Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum Benefit shown in the Schedule for this benefit, except as may be provided in “B” below.

**B. Additional for Plastic Surgery Expenses** – We will pay an additional benefit if a Covered Person requires skin grafting or plastic surgery due to an Injury covered under “A” above. The maximum amount We will pay for this benefit is shown in the Schedule.]

## **[PART VIII – MEDICAL EXPENSE – ILLNESS ONLY**

If Medical Expense – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Medical Expense** – If Illness begins within [0, 30, 60, 90 days] and results from the Covered Person's participation in the Covered Activity, and the Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum Benefit shown in the Schedule for this benefit, except as may be provided in "B" below.

**B. Preventative Inoculations** – We will pay the Reasonable and Customary Expense incurred for preventative inoculations received within 60 days of the date of a Covered Person's participation in a Covered Activity that caused exposure to a Illness including any additional expenses due to an allergic reaction to any preventative inoculations administered to the Covered Person subject to the Maximum Benefit shown in the Schedule.]

## **[PART IX – WEEKLY DISABILITY BENEFIT – INJURY ONLY**

If Weekly Disability Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

### **A. Total Disability Benefit**

We will pay benefits under this benefit "A" for Total Disability if such disability occurs as a direct result of Injury. The Injury must be the direct result of the Covered Person's participation in a Covered Activity.

We will pay the full weekly benefit shown in the Schedule for each week of the first 4 weeks of Total Disability. After the first 4 weeks of Total Disability, We will pay up to twice the weekly benefit shown in the Schedule, but not more than 100% of the Covered Person's Average Weekly Wage for such continued disability. In no event will We pay a benefit that is less than 25% of the weekly benefit shown in the Schedule for continued Total Disability.

Total Disability Inflation Provision – After the first 2 years of Total Disability for which We have paid benefits, We will increase additional benefits paid for that Total Disability. We will increase the benefit by 3% (compounded annually) for each additional year the Covered Person continues to be eligible for Total Disability benefits.

### **B. Partial Disability Benefit**

We will pay benefits under this benefit "B" for Partial Disability if such disability occurs as a direct result of Injury. The Injury must be:

- (1) the direct result of the Covered Person's participation in a Covered Activity; or
- (2) immediately following a period of Total Disability for which a benefit was paid under "A".

If the Partial Disability is the direct result of the Covered Person's participation in a Covered Activity, We will pay 50% of the weekly benefit shown in the Schedule for each of the first 4 weeks of Partial Disability. If the Partial Disability is immediately following a period of Total Disability for which a benefit was paid under "A", We will pay up to 50% of the weekly benefit shown in the Schedule but not more than 50% of the Covered Person's Average Weekly Wage for each of the first 4 weeks of Partial Disability.

After the first 4 weeks of Partial Disability, We will pay up to the full weekly benefit shown in the Schedule but no more than 50% of the Covered Person's Average Weekly Wage. In no event will We pay less than 12.5% of the weekly benefit shown in the Schedule.

### **Disability Provisions**

No benefits will be paid under this benefit after the date a benefit has been paid under the Permanent Physical Impairment Benefit – Injury Only.

Benefits for Total Disability as a result of any one Injury will not be paid for more than [5 years (260 weeks);10 years (520 weeks)]; [the lifetime of the Covered Person]. Benefits for Partial Disability will not be paid for more than [1 year (52 weeks); 5 years (260 weeks)] as a result of any one Injury. For any disability benefit of less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day of disability up to the applicable maximum.

If the Covered Person returns to his or her Regular Occupation on a full or part time basis within 5 years of the date of the Injury and, after receiving benefits for Total Disability, he is thereafter unable to perform the material and substantial duties of his or her Regular Occupation, he may return to a Total Disability status provided the attending Physician certifies a return to Total Disability status.

Periods of Total Disability or Partial Disability separated by less than 26 weeks will be considered one period of disability unless due to separate and unrelated causes

In the event the disability benefits received under the Policy plus disability benefits received under Workers' Compensation and any Other Valid and Collectible Insurance exceed the limits of "A" or "B", benefits will be reduced. Benefits will be reduced so the Covered Person will receive no more than 100% of his or her Average Weekly Wage for Total Disability under "A" and not more than 50% of his or her Average Weekly Wage for Partial Disability under "B". This will not affect the minimum benefit amount outlined above of 25% for Total Disability or 12.5% for Partial Disability.

[If a Covered Person is approved for disability retirement or otherwise retires, any retirement income offsets the Disability Benefits payable under this Policy.]

#### **[PART X – WEEKLY DISABILITY BENEFIT – ILLNESS ONLY**

If Weekly Disability Benefit – Illness Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

##### **A. Total Disability Benefit**

We will pay benefits under this benefit "A" for Total Disability if such disability occurs as a direct result of Illness. The Illness must be the direct result of the Covered Person's participation in a Covered Activity.

We will pay the full weekly benefit shown in the Schedule for each week of the first [4] weeks of Total Disability. After the first [4] weeks of Total Disability, We will pay up to twice the weekly benefit shown in the Schedule, but not more than 100% of the Covered Person's Average Weekly Wage for such continued disability. In no event will We pay a benefit that is less than [25%] of the weekly benefit shown in the Schedule for continued Total Disability.

Total Disability Inflation Provision – After the first 2 years of Total Disability for which We have paid benefits, We will increase additional benefits paid for that Total Disability. We will increase the benefit by 3% (compounded annually) for each additional year the Covered Person continues to be eligible for Total Disability benefits.

##### **B. Partial Disability Benefit**

We will pay benefits under this benefit "B" for Partial Disability if such disability occurs as a direct result of Illness. The Illness must be:

- (1) the direct result of the Covered Person's participation in a Covered Activity; or
- (2) immediately following a period of Total Disability for which a benefit was paid under "A" above.

If the Partial Disability is the direct result of the Covered Person's participation in a Covered Activity, We will pay 50% of the weekly benefit shown in the Schedule for each of the first 4 weeks of Partial Disability. If the Partial Disability is immediately following a period of Total Disability for which a benefit was paid under "A", We will pay up to 50% of the weekly benefit shown in the Schedule but not more than 50% of the Covered Person's Average Weekly Wage for each of the first 4 weeks of Partial Disability.

After the first 4 weeks of Partial Disability, We will pay up to the full weekly benefit shown in the Schedule but no more than 50% of the Covered Person's Average Weekly Wage. In no event will We pay a benefit less than 12.5% of the weekly benefit shown in the Schedule.

## **Disability Provisions**

No benefits will be paid under this benefit after the date a benefit has been paid under the Permanent Cardiac Impairment Benefit.

Benefits for Total Disability as a result of any one Illness will not be paid for more than [5 years (260 weeks); 10 years (520 weeks)] [or] [to age [67],] [whichever is longer]. Benefits for Partial Disability will not be paid for more than [1 year (52 weeks); 5 years (260 weeks)] as a result of any one Illness. For any disability benefit of less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day of disability up to the applicable maximum.

If the Covered Person returns to his or her Regular Occupation on a full or part-time basis after receiving benefits for Total Disability, and he is unable to perform the material and substantial duties of his or her Regular Occupation, he may return to Total Disability status provided the attending Physician certifies a return to Total Disability status.

Periods of Total Disability or Partial Disability separated by less than 26 weeks will be considered one period of disability unless due to separate and unrelated causes.

In the event the disability benefits received under the Policy plus disability benefits received under Workers' Compensation and any Other Valid and Collectible Insurance exceed the limits of "A" or "B", benefits will be reduced. Benefits will be reduced so the Covered Person will receive no more than 100% of his or her Average Weekly Wage for Total Disability under "A" nor more than 50% of his or her Average Weekly Wage for Partial Disability under "B". This will not affect the minimum benefit amount outlined above of 25% for Total Disability or 12.5% for Partial Disability.

[If a Covered Person is approved for disability retirement or otherwise retires, any retirement income offsets the Disability Benefits payable under the Policy.]

### **[PART XI – FAMILY EXPENSE BENEFIT – INJURY OR ILLNESS**

If Family Expense Benefit – Injury Or Illness coverage is selected on the Schedule, We will pay the Benefit as shown below.

If We pay benefits under Part I, Part II, Part III, Part VII or Part VIII, We will also pay the following additional benefits for the Reasonable and Customary Expenses incurred on behalf of the Covered Person within 52 weeks of the date of Injury or Illness:

- (1) medically necessary family counseling;
- (2) training of an Immediate Family member to perform rehabilitative or custodial functions necessary to the rehabilitation or care of the Covered Person;
- (3) transportation, meals and lodging expenses of the Immediate Family members incurred for visiting the Covered Person if he is receiving medical treatment on an inpatient basis more than 35 miles from the Covered Person's permanent residence;
- (4) loss of earnings by a Covered Person's Immediate Family member not to exceed 100% of the individual Immediate Family member's Average Weekly Wage, due to and as a direct result of a covered Injury or Illness sustained by the Covered Person.

The Maximum Benefit payable under this benefit is shown in the Schedule.]

### **[PART XII – FAMILY EDUCATION BENEFIT**

If Family Education Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If benefits are payable for the loss of life of a Covered Person under Part I, We will also pay the following benefits:

### **A. Dependent Child Benefit**

We will pay the annual tuition actually incurred at an Institution of Higher Learning, excluding room and board, by each Dependent Child of the deceased Covered Person. This benefit is payable only if on the date of the Covered Person's death, the Dependent Child is:

- (1) enrolled as a full time student at an Institution of Higher Learning above the 12<sup>th</sup> grade level; or
- (2) under age 21 and enrolls as a full time student at an Institution of Higher Learning above the 12<sup>th</sup> grade level within 24 months of the date of the Covered Person's death.

If the Dependent Child remains continuously enrolled as a full time student at such institution, We will pay up to the Maximum Benefit shown in the Schedule for this benefit for each year the Dependent Child is enrolled at such institution, for up to 4 consecutive years.

### **B. Surviving Spouse or Domestic Partner Benefit**

We will pay the annual tuition actually incurred at an Institution of Higher Learning, excluding room and board, by the Surviving Spouse or Domestic Partner of the deceased Covered Person. This benefit is payable only if the Surviving Spouse or Domestic Partner enrolls in an Institution of Higher Learning within 48 months of the date of the Covered Person's death.

We will pay up to the Maximum Benefit shown in the Schedule for this benefit for each year the Surviving Spouse is enrolled at such institution, for up to 4 consecutive years.

### **C. Other Benefit**

If no person qualifies for the benefits described in "A." or "B." above, We will pay a benefit of \$5,000 to the Covered Person's primary beneficiary. If no beneficiary is named We will pay the amount to the Covered Person's estate. We will not pay more than a total benefit of \$5,000 under this benefit "C".]

## **[PART XIII – ATHLETICS AND SPECIAL EVENTS BENEFIT – INJURY ONLY**

If Athletics And Special Events Benefit – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results from participation in or travel directly to or from Athletic Games, Contests or Special Events, We will pay the following:

### **A. Medical Expense Benefit – Injury only**

If, as the result of Injury, a Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum shown in the Schedule for one Injury.

### **B. Total Disability Benefit – Injury Only**

We will pay the weekly benefit for this benefit "B" if the Covered Person becomes Totally Disabled within 30 days after the date of Injury. For any Total Disability benefit paid for less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day the Covered Person is disabled up to the applicable maximum. We will pay up to a maximum of 52 weeks for any one accident.]

## **[PART XIV – HIV BENEFIT**

If HIV Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

### **A. HIV Lump Sum Benefit**

We will pay the Principal Sum for this benefit "A" if a Covered Person becomes infected with the Human Immunodeficiency Virus (HIV) as a direct result of participation in a Covered Activity. Payment made by Us under the Policy will end any right to collect any other benefits under the Policy. This benefit will be paid only if:

- (1) the Covered Person suffers exposure to HIV as a direct result of participating in a Covered Activity. Exposure means mucous-membrane, eye, or skin contact with blood, blood products, or other potentially infectious body fluids from a person with known HIV-positive serostatus, one clinically diagnosed with AIDS, or a high-risk person with compatible signs and symptoms; and

- (2) an incident report describing how the Covered Person was exposed to HIV is filed with the Policyholder within 72 hours of participation in the Covered Activity during which the Covered Person was exposed to HIV; or
- (3) the date on which the Covered Person became aware of such exposure; and
- (4) the incident report described in (2) above is filed with Us within 7 days of the date that it was filed with the Policyholder; and
- (5) the Covered Person is tested for the presence of HIV antibodies in their blood within 7 days of the date such report was filed with Us, and, must test negative utilizing a preliminary screening test approved by the Federal Food & Drug Administration (FDA); and
- (6) the Covered Person tests positive for the presence of HIV antibodies in their blood within 52 weeks of participation in the Covered Activity during which the Covered Person was exposed to HIV utilizing a positive screening test approved by the FDA.

We will pay for the Reasonable and Customary Expense of the tests described in (5) and (6) above.]

**[B. HIV Infection Prevention Benefit**

We will pay the Reasonable and Customary Expense of postexposure prophylaxis if a Covered Person suffers exposure to HIV as a direct result of participation in a Covered Activity. Exposure means mucous-membrane, eye, or skin contact with blood, blood products, or other potentially infectious body fluids from a person with known HIV-positive serostatus, one clinically diagnosed with AIDS, or a high-risk person with compatible signs and symptoms. This benefit will be paid only if such prophylaxis is recommended by the attending Physician; and it complies with the HIV postexposure prophylaxis (PEP) guidelines of the Center for Disease Control and Prevention (CDC), an agency of the U.S. Department of Health and Human Services.

If the Covered Person participates in an HIV PEP Protocol in accordance with this benefit “B” and as a direct result suffers loss of life, We will pay an amount equal to the Principal Sum shown in the Schedule for benefit “A” of this Part XII.

In no event will death benefits be paid or payable under this benefit “B” if a death benefit is paid or payable under benefit “A” of this Part XII as a result of participation in the same Covered Activity.

We will not pay more than the Maximum shown in the Schedule.]

**[PART XV – PHYSICAL ASSAULT BENEFIT – INJURY ONLY**

If Physical Assault Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

A. If a benefit is payable for Injury under Part I, Part II or Part III of the Policy, We will pay an additional benefit equal to 25% of the total benefit paid under such Part I, Part II or Part III, or the Maximum shown in the Schedule for this Part XIII, whichever is more, if such Injury is caused by Physical Assault committed by a person other than a Covered Person, while traveling to or from emergency duty or while at the emergency duty.

B. If no benefit is payable for Injury under Part I, Part II or Part V of the Policy, but benefits are payable for Injury under “A” or “B” of Part VII or Part VIII of the Policy, We will pay an additional lump sum benefit equal to the Maximum shown in the Schedule, if such Injury is caused by Physical Assault committed by a person other than a Covered Person.]

**[PART XVI – DAY CARE EXPENSE BENEFIT – INJURY OR ILLNESS**

If Day Care Expense Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person is Totally Disabled as a result of Injury or Illness and benefits are payable under Part VII, Part VIII, Part IX or Part X of the Policy, and the Day Care Expense is incurred solely as a result of the covered Injury or Illness, We will pay an additional benefit up to the Maximum shown in the Schedule for Day Care Expense necessarily incurred by the Covered Person during the period of Total Disability.]

**[PART XVII – PERMANENT PHYSICAL IMPAIRMENT EDUCATION BENEFIT – INJURY ONLY**

If Permanent Physical Impairment Education Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If Injury to a Covered Person results in Permanent Physical Impairment, We will pay this benefit only if the Covered Person:

1. is Totally Disabled or Partially Disabled as a result of such Injury; and
2. has participated in an approved physical rehabilitation program, if his or her physical condition so warrants, and has reached their Maximum Medical Improvement; and
3. elects to accept a lump sum benefit under Part II, and notifies Us of such election by registered mail within the Period of Eligibility.

Determination of the Benefit Payable:

We will provide this benefit upon a written agreement between the Covered Person and Us for the program of education for retraining in an Institution of Higher Learning. Coverage will include charges for tuition and books as specified in the written agreement. Tuition must be incurred for the purpose of learning a new skill or trade and with the reasonable expectation that the Covered Person may find gainful employment as a result. We will not pay this benefit for any tuition incurred by the Covered Person more than 156 weeks after the end of the Period of Eligibility. We will not pay more than the Maximum shown in the Schedule.

We will not pay for the cost of any tuition incurred by a Covered Person that is paid or payable under Workers' Compensation or any Other Valid and Collectible Insurance.]

**[PART XVIII – RESIDENCE AND VEHICLE ADAPTATION EXPENSE BENEFIT**

If Residence and Vehicle Adaptation Expense Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If the Covered Person suffers an Injury or Illness which results in a permanent irrevocable loss for which benefits are payable under the Policy and inhibits the Covered Person's ability to maintain independence in their residence or vehicle, We will pay up to the benefit shown in the schedule if:

- (1) the Residence and Vehicle Adaptation Expense was not necessary prior to the Covered Activity that caused the Injury or Illness; and
- (2) Residence and Vehicle Adaptation Expenses are incurred as a direct result of the Injury or Illness; and
- (3) the Residence and Vehicle Adaptation Expenses are incurred within 12 months of Covered Activity that caused the Injury or Illness;
- (4) Residence and Vehicle Adaptation Expenses are made in accordance with any applicable laws or requirements for approval by the appropriate government authorities;
- (5) Residence and Vehicle Adaptation Expenses are made by a person or persons experienced in such alterations and such alterations or modifications are recommended and approved by a recognized organization, providing support and assistance to impaired individuals; and
- (6) the Residence and Vehicle Adaptation Expenses are agreed to and approved by Us.

We will pay up to the Maximum Benefit shown in the Schedule for this benefit for:

1. The one-time cost of alterations to the injured Covered Person's residence to make it accessible and habitable for an impaired individual; and
2. The one-time cost of modifications necessary to a motor vehicle, owned by the injured Covered Person, to make the vehicle accessible or drivable for the Covered Person.

We will pay the Residence and Vehicle Adaptation Expenses in excess of benefits received under Workers' Compensation and any Other Valid and Collectible Insurance.]

**[PART XIX – CONTINUATION OF COVERAGE BENEFIT – INJURY ONLY**

If Continuation of Coverage – Injury Only coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person is Totally Disabled as a result of Injury and benefits are payable under Part II, Part VII or Part VIII of the Policy, We will pay the cost of group medical insurance coverage up to a maximum of \$500 per month for up to a total maximum of \$6,000, not to exceed 18 months. The Covered Person must purchase the group medical insurance coverage on an individual basis from his or her former employer pursuant to any available continuation of coverage and during the period of Total Disability payable under the Policy.

Coverage will only apply if the Covered Person provides Us with acceptable documentation from his or her employer stating that the sole reason that the Covered Person is eligible for continuation benefits is because his or her employment was terminated because of his or her Total Disability.]

**[PART XX – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT – INJURY ONLY  
[Off-Duty Coverage] [24-Hour Coverage]**

If Accidental Death and Dismemberment Benefit – Injury Only is selected on the Schedule, We will pay the Benefit as shown below.

**A. Loss of Life**

If Injury to a Covered Person results in loss of his or her life, We will pay a benefit under this Part XX. The benefit amount We will pay is shown in the Schedule.

**B. Dismemberment Loss**

If Injury to a Covered Person results in a dismemberment loss listed in Part I “A” in the Policy, We will pay a benefit for such loss under this Part XX. The benefit amount We will pay is shown in the Schedule.

**C. Loss of Life – Military Duty**

If Injury to a Covered Person results in loss of his or her life while serving in the military, armed forces or units auxiliary thereto, We will pay a benefit under this Part XX. The benefit amount We will pay is shown in the Schedule. Exclusion (3) of Section 8 Exclusions does not apply to this benefit.

[Benefit XX A. and B. will not be paid if a benefit is paid under Part I “A” of the Policy.]

**[PART XXI – BURIAL AND CREMATION BENEFIT**

If Burial and Cremation Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

We will pay the amount shown in the Schedule for burial or cremation of the Covered Person who dies from an Injury or Illness resulting directly; and independently of all other causes; from a Covered Activity.]

**[PART XXII – SURVIVOR BENEFITS**

If Survivor Benefits coverage is selected on the Schedule, We will pay the Benefit as shown below.

**A. Child**

We will pay this benefit shown in the Schedule of Benefits subject to the following conditions, if the Covered Person’s death results directly; and independently of all other causes; from a Covered Activity and he or she is survived by a Covered Dependent Child.

If the Covered Dependent Child was under the age of majority at the time of the Covered Person’s death, a Child Survivor Benefit, plus interest, will be paid in one lump sum to each surviving Covered Dependent Child when he or she attains the age of majority. Interest will be compounded annually at a rate equal to the arithmetic average of the 52-week U.S. Treasury notes as published by a financial authority designated by Us. If the Covered Dependent child dies before this benefit is payable, this benefit will then be payable to the Covered Dependent Child’s estate.

If a surviving Covered Dependent Child is the age of majority or over at the time of the Covered Person’s death, the benefit will be payable in one lump sum when We receive the claim. If there is no surviving Covered Dependent Child at the time of the Covered Person’s death, a default benefit will be paid to the Covered Person’s beneficiary.

Benefits will not be paid if a claim is submitted to Us more than one year after the Covered Person's death, or if submitted earlier and he or she is under the age of majority at the time of the Covered Person's death, the child is not a Covered Dependent.

### **B. Spouse or Domestic Partner**

We will pay this benefit shown in the Schedule of Benefits if the Covered Person's death results directly; and independently of all other causes; from a Covered Activity and he or she is survived by a Surviving Spouse or Domestic Partner.

### **C. Elder**

We will pay this benefit shown in the Schedule of Benefits if the Covered Person's death results directly; and independently of all other causes; from a Covered Activity and he or she is survived by a Dependent Parent.

The Elder Survivor Benefit will be payable in equal shares to the Dependent Parents. Only one Elder Survivor Benefit will be payable regardless of the number of Dependent Parents.

Dependent Parent(s) means the Covered Person's parent; parent-in-law; grandparent; grandparent-in-law; great-grandparent; or great-grandparent-in-law (whether natural; step; or adoptive), who is:

- (1) not regularly employed on a full-time basis;
- (2) primarily dependent upon the Covered Person for support and maintenance due to a proven mental disability or physical handicap;
- (3) residing in the Covered Person's home; and
- (4) eligible to be claimed as an exemption on the Covered Person's federal income tax return.]

### **[PART XXIII – TRANSITION BENEFIT**

If Transition Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

If a Covered Person is given a release to return to his or her primary employer after having received benefits under the Policy for a Covered Injury or Covered Illness, but his or her primary employer has terminated his or her employment due to the Covered Injury or Covered Illness, we will continue to pay disability benefits previously payable for a period of up to 26 weeks while the Covered Person actively seeks employment.]

### **[PART XXIV – CRITICAL/TRAUMATIC INCIDENT STRESS MANAGEMENT TEAM BENEFIT**

If Critical/Traumatic Incident Stress Management Team coverage is selected on the Schedule, We will pay the Benefit as shown below.

We will pay the reasonable and customary expenses incurred by a Critical Incident Stress Management Team when such services are: (1) requested and authorized by the Policyholder; and (2) are required as a result of the Covered Person's participation in a specific Covered Activity in which a Traumatic Incident occurred while coverage under the Policy is in force. Covered expenses are those for necessary transportation, meals, and lodging. We will not pay more than the Maximum shown in the Schedule regardless of the number of Covered Persons treated.]

### **[PART XXV EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFIT**

If Emergency Medical Evacuation and Repatriation Benefit coverage is selected on the Schedule, We will pay the Benefit as shown below.

We will pay Covered Expenses incurred up to the maximum shown in the Schedule , subject to the following conditions for emergency medical evacuation, if:

1. The Covered Person suffers a Covered Loss resulting directly; and independently of all other causes; from a Covered Accident that occurs while traveling from his or her principal residence to another city or foreign country, with at least {100} miles distance.
2. The Covered Person's attending Physician certifies an emergency need to send the Covered

Person, under medical supervision, to [the nearest] [a different] medical facility.

Covered expenses include:

1. charges for ambulance services required while transporting the Covered Person to the nearest appropriate treatment facility; or
2. charges for medical services required to send the Covered Person to the nearest appropriate treatment facility; or
3. reimbursement of [economy] [business] [first] class transportation charges for return of the Covered Person from the treatment facility to home, paid for by the Covered Person within 1 year (52 weeks) from the date he or she was first scheduled to return from the trip. Any refunds paid or payable from the unused transportation tickets will reduce benefits; or
4. charges for necessary travel expenses of an escort; such travel expenses are limited to food; hotel room; and economy class transportation charges; and
5. the charges incurred that are medically necessary and do not exceed the usual and customary charges for similar treatment, services, or supplies in the locality where the expense is incurred; and do not include charges that would not have been made if there were no insurance.

Benefits will not be payable unless: We authorize in writing, or by an authorized electronic means, all expenses in advance, and services are rendered by Our assistance provider. The Covered Person must, at his or her own expense, furnish: travel invoices, medical reports or records, or other documents We require to determine if benefits are payable. Benefits will be paid to the party who actually paid for the expenses upon Our receipt of satisfactory proof that the expense was paid.

If the Covered Person pays eligible expenses for a Covered Loss for which We believe a third party is liable, We will pay the benefits for emergency medical evacuation. However, if the Covered Person recovers payment from the third party, he or she must refund to Us the lesser of:

1. the amount We paid for the eligible expenses; or
2. an amount equal to the sum received from the third party for such expenses.

Benefits will not be paid for any of the following:

1. expenses that exceed the Maximum Benefit;
2. services not pre-approved by Us, or for services performed by a vendor not authorized by Us; or
3. expenses paid or payable by any Workers' Compensation, occupational disease or similar law that would pay emergency medical evacuation expenses in the absence of this benefit.]

#### **[PART XXVI REPATRIATION BENEFIT**

We will pay Eligible Expenses, as shown in the Schedule of Benefits, incurred for the return of the Covered Person's remains to his or her place of residence in his or her home country and state if the Covered Person's death results directly; and independently of all other causes; from a Covered Accident outside of his or her home state or more than {1 00} miles from the Covered Person's place of residence.

"Eligible Expenses" means costs, pre-approved by Us and incurred for embalming; cremation; coffin or urn; transportation of the body or remains; necessary travel expenses of an escort. Necessary travel expenses are limited to food; hotel room; and economy class transportation charges. ]

#### **[PART XXVII - OPTIONAL BENEFITS**

If one or more Optional Benefits are selected on the Schedule, We will pay the Benefit(s) as shown below.

##### **A. [Additional Weekly Disability Benefit**

If a Covered Person becomes Totally Disabled and is eligible for benefits under Part IX or Part X of the Policy, We will pay an additional weekly disability benefit. We will pay this benefit for the first week the Covered Person is Totally Disabled. For less than 1 week, We will pay one-seventh (1/7) of the weekly benefit for this benefit for each full day of Total Disability. We will pay this in addition to any other weekly benefit payable under the Policy.]

##### **[B. Weekly Hospital Indemnity Benefit**

We will pay a weekly hospital indemnity benefit if:

1. benefits are also payable under Part IX or Part X of the Policy; and

2. the Covered Person requires Hospital confinement for any Injury or Illness.

This benefit starts on the first day the Covered Person is confined in a Hospital. We will pay one-seventh (1/7) of the weekly benefit for this Benefit for each day of confinement. We will not pay for more than 104 weeks as a result of any one Injury or Illness.]

**[C. Auxiliary Member Benefits – Injury Only**

If Injury to a Covered Auxiliary Member results from participation in a Covered Activity, We will pay the following:

**1. Indemnity Benefits**

We will pay for the losses listed in “A” of Part I of the Policy, subject to the Principal Sum listed in the Schedule for this benefit if an Injury results in a Covered Loss.

**2. Medical Expense Benefit**

If as the result of an Injury, an Auxiliary Member is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care; We will pay the Reasonable and Customary Expense incurred for such services. We will not pay more than the Maximum shown in the Schedule.

**3. Weekly Disability Benefit**

We will pay the weekly benefit shown in the Schedule if the Auxiliary Member becomes Totally Disabled within 30 days after the date of Injury. For any benefit provided for less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day the Auxiliary Member is Totally Disabled up to the applicable maximum. We will pay up to a maximum of 1 year (52 weeks) for any one accident.]

**[D. Organized Team Sports Benefit**

We will pay the benefits described below if a Covered Person suffers a Sports Injury:

**1. Accidental Death and Dismemberment or Loss of Sight**

If Sports Injury to a Covered Person results in loss of his or her life, We will pay the Principal Sum shown in the Schedule for this benefit. If Sports Injury to a Covered Person results in any one of the other losses listed below, We will pay a percentage of the Principal Sum shown in the Schedule for that loss as listed below:

<b><u>For “Loss” of:</u></b>	<b><u>% of Principal Sum</u></b>
One Arm	75%
One Leg	75%
One Hand	50%
One Foot	50%
Entire Sight of One Eye	50%

“Loss” means, with reference to the hand or foot, the complete severance through or above the wrist or ankle joint; and with reference to the arm or leg, the complete severance through or above the elbow or knee joint. Loss of sight means the total and irrecoverable loss of sight.

If the Covered Person suffers more than one Covered Loss as a result of any one accident, multiple benefits under “1” above will be paid to the extent that one benefit does not duplicate another benefit of the Policy.

For example, if a Covered Person loses an arm in an accident, we will pay for “Loss of One Arm” but not for “Loss of One Hand.” If the Covered Person loses an arm and, in the same accident, is blinded in one eye, we will pay for “Loss of One Arm” and “Loss of Entire Sight in One Eye.” However, under no circumstances, will we pay more than 100% of the Principal Sum shown in the Schedule for this benefit for all Covered Losses resulting from any one accident.

## 2. Medical Expense

If, as the result of a Sports Injury, and beginning within 90 days of the date the Sports Injury occurred, a Covered Person is required to: (1) receive treatment from a Physician; (2) be confined in a Hospital; (3) receive the services of a licensed nurse upon the recommendation of a Physician; or (4) receive Home Health Care, We will pay the Reasonable and Customary Expense incurred for such services.

We will not pay more than the Maximum shown in the Schedule for this benefit. We will not pay for any expenses incurred more than 1 year (52 weeks) after the date that the Sports Injury occurred. We will only pay for those expenses that are in excess of the Medical Expense Deductible shown in the Schedule for this benefit.

## 3. Weekly Disability

We will pay the Disability Benefit shown in the Schedule for this benefit if the Covered Person becomes Totally Disabled within 30 days after the date the Sports Injury occurred. We will pay the Disability Benefit for each week that the Covered Person remains Totally Disabled but not for more than the maximum number of weeks shown on the Schedule . For any benefit provided for less than a week, We will pay one-seventh (1/7) of the Disability Benefit for each full day the Covered Person is Totally Disabled. The Waiting Period for this benefit begins on the date that the Sports Injury occurred and ends after the number of days have expired. We will not pay any benefits during the Waiting Period.]

## SECTION 7: HAZARDS INSURED AGAINST

We will pay benefits as shown in the Schedule of Benefits and described in the Policy when a Covered Person suffers a Covered Loss as a result of participation in a Covered Activity.

## SECTION 8: EXCLUSIONS

We will not pay benefits for any loss that is caused by, or results from:

- (1) [Suicide; self-destruction; attempted self-destruction while sane or insane; or intentionally self-inflicted Injury.]
- (2) [War or any act of war; declared or undeclared.]
- (3) [Service in the military or armed forces or units auxiliary thereto.]
- (4) [Illness, except as directly caused by and directly resulting from participation in a Covered Activity as provided by the Policy.]
- (5) [Mental or emotional disorders, except as specifically provided under the Post Traumatic Stress Disorder Benefit.]
- (6) [Alcoholism; drug addiction; or the use of any drug or narcotic except as prescribed by a Physician.]
- (7) [Injury that occurs while on board any type of aircraft while the aircraft is taking off, airborne, or landing. This exclusion does not apply to Injury to a Covered Person who is a passenger on an aircraft and is participating in a Covered Activity. However, no coverage is provided under any circumstances for Injury that occurs during or arising out of a planned parachute jump from an aircraft. Also, no coverage is provided if the Covered Person is the pilot or operator.]
- (8) [Any activity in football, ice hockey, field hockey, lacrosse, soccer, rugby and boxing.]
- (9) [Injury or Illness sustained by a Covered Person while operating, or riding as a passenger in, a motor vehicle if such Injury or Illness occurs as a direct result of the Intoxication of the Covered Person.]
- (10) [Under any Weekly Disability Benefit or Athletics and Special Events Benefit of the Policy, any loss caused by or resulting from Injury or Illness sustained by a registered Junior Member unless:
  - (a) such member is eligible for coverage under Workers Compensation, or other similar or comparable coverage; or
  - (b) such member has had full-time or part-time gainful employment during any part of the 12-month period immediately preceding the Injury or Illness, and the Average Weekly Wage applying to such member exceeds \$1.00.]

## SECTION 9: CLAIM PROVISIONS

**Notice Of Claim:** A claimant must give Us or Our authorized representative written (or authorized electronic) notice of claim within 90 days after any Covered Loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. This notice should identify the Covered Person, the Covered Person's address, the Policyholder name, and the Policy Number.

**Claim Forms:** Upon receiving notice of a claim, We will send claim forms to the claimant within 15 days. If We do not furnish such claim forms, the claimant will satisfy the requirements of written proof of loss by sending the written (or authorized electronic or telephonic) proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

**Proof Of Loss:** Written (or authorized electronic or telephonic) proof of loss must be sent to Us or Our authorized representative. Written (or authorized electronic) proof must be given within 90 days after the date of loss. If it cannot be provided within that time, it should be sent as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted if it is sent later than one year from the time proof is otherwise required.

For disability for which benefits may be payable for at least 2 years, the Covered Person must give Us notice of continuance of such disability, except in the event of legal incapacity. The notice must be given to Us every 6 months following the submission of the initial claim for benefits. The proof of loss will be considered a 6-month notice and notice will be required every 6 months thereafter. Delay in giving Us notice of a continuing disability will not affect the Covered Person's right to benefits otherwise accruing for the 6-month period before the date notice is actually given to Us.

The Covered Person is responsible for providing all necessary information to substantiate the validity of their claim.

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

**Time Payment Of Claims:** Any benefits due will be paid immediately after We receive written (or authorized electronic) proof of loss.

**Payment Of Claims:** We or Our authorized representative will pay a claim after receipt of acceptable proof of loss. If the Covered Person dies, any death benefits or other benefits unpaid at the time of the Covered Person's death will be paid to the Covered Person's beneficiary. If no beneficiary is designated by the Covered Person, payment will be made to the first surviving class of the following classes:

1. Covered Person's spouse;
2. Covered Person's children, in equal shares (If a child is a minor, benefits will be paid to the legal guardian);
3. Covered Person's mother or father, in equal shares;
4. Covered Person's brothers or sisters, in equal shares;

Otherwise, benefits will be paid to the Covered Person's estate.

All other benefits due are payable to the Covered Person. In the event the Covered Person is a minor, incompetent or otherwise unable to give a valid release for the claim, We may make arrangements to pay claims to the Covered Person's legal guardian, committee or other qualified representative.

We may pay medical expense benefits provided under the Policy directly to the provider rendering covered services, unless the Covered Person requests otherwise in writing. The Covered Person must make the request no later than the time he or she files a written proof of loss.

All payments made in good faith will discharge Our liability to the extent of the claim.

**Beneficiary:** The Covered Person may designate a beneficiary. The Covered Person has the right to change the beneficiary at any time by written (or authorized electronic) notice. If the Covered Person is a minor, his or her parent or guardian may exercise this right for him or her. The change will be effective

when it is received by the Policyholder. When received, the effective date is the date the notice was signed. We are not liable for any payments made before the change was received. We cannot attest to the validity of a change.

The Covered Person is the beneficiary for any Covered Dependent.

**Physical Examinations and Autopsy:** We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy. [Failure to submit to an examination two (2) consecutive times will result in termination of benefits, unless a reasonable explanation is provided or reasonable attempts to reschedule the examination are made.]

**Legal Actions:** No lawsuit or action in equity can be brought to recover on the Policy until there has been full compliance with all the terms of the Policy. All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No lawsuit or action in equity may be brought to recover on the Policy: (1) before sixty (60) days following the date proof of loss was given to Us; or (2) after three (3) years following the date proof of loss is required.

**Recovery of Overpayment or Error:** If benefits are overpaid, or paid in error, We will notify the Covered Person in writing of the circumstances surrounding the overpayment. Within sixty (60) days of receipt of the original notification, the Covered Person is required to repay Us the amount of overpayment.

Within thirty (30) days of receipt of the original notification, the Covered Person may request, in writing, additional information in regard to the overpayment. Your request to Us will not extend or modify the overpayment amount or time unless the Covered Person is notified by Us in writing.

We have the right to recover the amount overpaid, or paid in error, by any or all of the following methods:

1. A request for lump sum payment of the amount overpaid, or paid in error;
2. Reduction of any proceeds payable under the Policy by the amount overpaid, or paid in error; or
3. Taking any other action available to Us.

**Right of Recovery:** A Covered Person may incur expenses due to an Injury or Sickness covered by the Policy. The loss may be caused by the act or omission of another person. If so, the Covered Person may have a claim against that other person for payment of expense incurred charges. If recovery is made, the Covered Person must repay Us the Recovery made from: (a) the other person, or (b) the other person's insurer. We will only have such right against excess funds after the Covered Person is made whole.

Recovery means monies paid to the Covered Person through judgment, settlement or otherwise to compensate for losses caused by the Injury or Sickness, less attorney's fees and court costs incurred in making the Recovery. This Right of Recovery provision also applies when a Covered Person receives payment under an uninsured or underinsured motorist insurance policy or plan.

**Other Coverage with Us:** If the Covered Person is covered under more than one similar Policy issued by Us, the total benefits payable will not exceed those payable under the Policy which provides the largest benefit.

**Facility of Payment:** A payment made under another plan may include an amount that should have been paid under this plan. If it does, We may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" means the reasonable cash value of the benefits provided in the form of services. "Payment made" includes providing benefits in the form of services.

**Exposure and Disappearance:** If, by reason of an accident, a Covered Person is unavoidably exposed to the elements and as the result of such exposure suffers a loss for which indemnity is otherwise payable, such loss will be covered under the terms of the Policy.

If the body of a Covered Person has not been found within one (1) year after the date of disappearance as the result of the sinking or wrecking of the aircraft or watercraft in which the Covered Person was riding at the time of the accident and under such circumstances as would otherwise be covered, it will be

presumed that the Covered Person suffered loss of life resulting from Injury caused solely by a Covered Accident.

**Subrogation:** To the extent the Company pays for a loss suffered by a Covered Person, the Company will take over the rights and remedies the Covered Person had relating to the loss. This is known as subrogation. The Covered Person must help the Company to preserve its rights against those responsible for the loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over an Covered Person's rights, the Covered Person must sign an appropriate subrogation form supplied by the Company. As permitted by law, the Company has the right to offset future benefits payable to the Covered Person under the Policy against any such Recovery.

## SECTION 10: PREMIUM PROVISIONS

**Premiums:** The premiums for the Policy will be based on the rates currently in force, the plan, and amount of insurance and benefits in effect.

**Payment of Premium:** The first premium is due on the Policy Effective Date. After that, premiums will be due annually unless We agree with the Policyholder on some other method of premium payment. The Policyholder shall remit the premium to Us or Our authorized representative.

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

**Grace Period:** A Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

## SECTION 11: GENERAL PROVISIONS

**Other Coverage With This Company:** If the Covered Person is covered under more than one similar policy issued by Us, the total benefits payable will not exceed those payable under the policy which provides the largest benefit.

**Entire Contract; Changes:** The Policy (including any endorsements or amendments), and the signed application of the Policyholder are the entire contract. Any statements made by the Policyholder or Covered Persons will be treated as representations and not warranties. No such statement shall void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application and a copy is provided to the person who made such statement (or their beneficiary or representative).

To be valid, any change or waiver must be in writing. It must be signed by our President or Secretary and be attached to the Policy. No agent has authority to change or waive any part of the Policy.

**Policy Effective Date And Termination Date:** The Policy begins on the Policy Effective Date at 12:01 AM Standard Time at the address of the Policyholder where the Policy is delivered. Either We or the Policyholder may terminate the Policy on any Premium Due Date by giving 31 days advance written notice to the other party. The Policy may be terminated at any time by mutual written consent of the Policyholder and Us. The Policy terminates automatically on the earlier of: 1) the end of the Policy Term shown in the Schedule of Benefits; or 2) the Premium due date if Premiums are not paid when due, subject to the Grace Period. Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination.

**Clerical Error:** If a clerical error is made, whether by the Policyholder or by Us, it will not invalidate coverage otherwise validly in effect; nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to Us and is rectified promptly upon discovery. No error will continue the insurance of a Covered Person beyond the date it should end under the Policy terms.

**Data Required:** The Policyholder shall furnish Us with all information that We may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder in connection with the insurance, together with such records, as may have a bearing on the insurance under the Policy, shall be open for inspection by Us at all reasonable times.

**Examination Of Records And Audit:** We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after the termination of the Policy as they relate to the premiums or subject matter of this insurance.

**Certificates Of Insurance:** Where it is required by law, or upon the request of the Policyholder, We will make available to all Covered Persons certificates outlining the benefits of the Policy.

**Conformity With State Laws:** On the effective date of the Policy, any provision that is in conflict with the laws in the state where it is issued is amended to conform to the minimum requirements of such laws.

**Not In Lieu Of Workers' Compensation:** The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits and does not satisfy any requirements for coverage by any Workers' Compensation Act or similar law.

**New Entrants:** New eligible persons added from time to time to the Policyholder group will automatically be covered under the Policy.

**Assignment:** The Policy is not assignable, whether by operation of law or otherwise. Benefits may be assigned. No assignment of interest in loss of life benefits shall be binding on Us until the original or duplicate thereof is received by Us. We assume no responsibility for the validity of such assignment.

**Insolvency:** The insolvency; bankruptcy; financial impairment; receivership; voluntary plan of arrangement with creditors; or dissolution of the Policyholder will not impose upon Us any liability other than the liability defined in the Policy. The insolvency of the Policyholder will not make Us liable to the creditors of the Policyholder, including Covered Persons under the Plan.

**Incontestability:** Except for nonpayment of premiums, We will not contest the validity of the Policy after it has been in force for two years from its date of issue.

**Misrepresentation or Fraud:** The entire Policy will be void, whether before or after a loss, if We determine that the Policyholder; Covered Person; or its agent has concealed or misrepresented any material fact or circumstance concerning the Policy, including any claim or any case of fraud by the Policyholder; Covered Person; Third Party Administrator; or other agent relating to this Policy.

**Waiver:** Failure of the Company to strictly enforce its rights under this Policy at any time or under any circumstance shall not constitute a waiver of such rights by the Company at any time under the same or different circumstances.



[Administrative Address:  
One Liberty Plaza,  
53rd Floor  
New York, NY 10006  
(800) 817-3252]

**GENERAL INFORMATION**

Date of survey: \_\_\_\_\_ Renewal Date: \_\_\_\_\_ Date proposal needed: \_\_\_\_\_

Legal Name of Organization: \_\_\_\_\_  
(Include all organizations that are to be included as insureds including Fire Districts, Fire Companies, Rescue Squads and Auxiliaries)

FEIN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
County: \_\_\_\_\_

Website Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Chief: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Training Officer: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Inspection Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**INSURANCE AGENT INFORMATION**

Producer: \_\_\_\_\_ CSR or Other Contact \_\_\_\_\_

Name of Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Do you currently write this account?  Yes  No

If yes, for how long? \_\_\_\_\_ Carrier Name? \_\_\_\_\_

Is the account Sub-Brokered?  Yes  No

If yes, please indicate Agency Name and Address: \_\_\_\_\_

**BUSINESS INFORMATION**

Which best describes the organization (please check one):

- Fire Suppression only (no EMS)
- Fire and Rescue/EMS
- Rescue/EMS Squad or Ambulance Squad
- Other (please describe): \_\_\_\_\_

The organization is a (please check one):

- Tax District
- Independent Non-Profit Organization
- Municipal, Village or Town Department
- Other (please describe): \_\_\_\_\_

If a municipal, village or town department, is the organization a separate legal entity?  Yes  No

Population served on a first-call basis: \_\_\_\_\_ Years in operation: \_\_\_\_\_

Have you been Cancelled, Non-Renewed, Declined, or Cancelled in the past 3 years?  Yes  No

If Yes, Please Explain: \_\_\_\_\_

## OPERATIONS INFORMATION

Total Population Served on a First Call Basis: \_\_\_\_\_

Total number of emergency responses (excluding Mutual Aid) in the past twelve months (please attach a call-log if available):

Total Fire \_\_\_\_ Total Rescue \_\_\_\_ Total EMS \_\_\_\_

Does the organization service a major highway?  Yes  No

If yes, approximately how many rescue calls can be attributed to this service? \_\_\_\_\_

Does the organization service a resort area?  Yes  No

If yes, approximately how much does the population increase during peak season? \_\_\_\_\_

Total number of Volunteers, including Junior Members and Auxiliary Members: \_\_\_\_\_

Are all Volunteers currently covered by Workers Compensation Insurance?  Yes  No

Total number of Career (Paid) Personnel (works more than 750hrs annually): \_\_\_\_\_

Are all Career (Paid) Personnel currently covered by Workers Compensation Insurance?  Yes  No

Does the organization... (Please check all that apply)

Have a designated safety officer? Name: \_\_\_\_\_

Have a safety committee?

Require a minimum of 8 hours of safety training annually?

Require annual physicals for its members?

Have organized health and wellness initiatives (i.e. fitness program)?

Have and enforce a seatbelt policy?

Have an organized driver training program?

Utilize an incident command system on every call?

Require annual mask fit tests?

Have a safe lifting training program?

Have annual blood-borne pathogen training requirements?

Have power cots?

Have a policy and enforce the use of universal precautions?

Requires all officers be at least NIMS 200 certified?

Require all firefighters be least firefighter level 1 trained?

Hold any special events? Please describe: \_\_\_\_\_

## ACCIDENT PROGRAM BENEFITS

[Core Benefits	Select the Benefit Limits to be Included (choose one in each category)				
	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5
Indemnity Benefits					
Accidental Death & Dismemberment	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Illness Loss of Life	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Physical Impairment – Injury	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Physical Impairment – Illness	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Cardiac Impairment	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Burn Disfigurement	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
HIV	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Blanket Medical Expense	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000				
Weekly Disability Benefit (Week 1- 4 / Week 5+)	<input type="checkbox"/> \$100/\$200 <input type="checkbox"/> \$200/\$400 <input type="checkbox"/> \$300/\$600 <input type="checkbox"/> \$400/\$800 <input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$600/\$1,200				
Accidental Death & Dismemberment – Other than Covered Activity	<input type="checkbox"/> 24-Hour Coverage (includes Line of Duty) <input type="checkbox"/> Off Duty Coverage <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000				
Athletics & Special Events – Injury Only	Medical Expense <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 Total Disability – Per Week <input type="checkbox"/> \$100 <input type="checkbox"/> \$200				

**Additional Core Benefits** (included with Core benefits selected above – note that if indemnity, medical expense and weekly disability benefits are not all selected, not all of these benefits may apply)

[Additional Seatbelt Benefit – Injury Only	25% of Principal Sum]
[Post-Traumatic Stress Disorder	\$20,000]
[HIV Infection Prevention	\$3,500]
[Family Expense Benefit	\$25,000]
[Family Education Benefit	\$5,000]
[Plastic Surgery	\$10,000]
[Preventive Inoculations	\$10,000]
[Physical Assault Benefit – Injury Only	25% of Principal Sum]
[Day Care Expense Benefit	up to \$30 per day for up to 26 weeks]
[Permanent Physical Impairment Education	35% of Permanent Physical Impairment Benefit, not to exceed \$20,000]
[Continuation of Coverage – Injury Only	up to \$500 per month for 18 months, not to exceed \$6,000]
[Residence and Vehicle Adaptation Expense	\$15,000]
[Burial and Cremation	10% of Principal Sum, not to exceed \$5,000]
[Survivor (Child, Spouse or Domestic Partner, Elder)	10% of Principal Sum, not to exceed \$5,000]
[Critical/Traumatic Incident Stress Management Team	\$20,000]
[Transition Benefit	Weekly Disability Benefit for up to an additional 26 weeks]

**Optional Benefits** (select the optional benefits to be included)

[Career Personnel (Career Personnel will receive same benefits selected for Volunteers):	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[Full Auxiliary* (Auxiliary Members will receive same benefits selected for Volunteers):	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[Emergency Evacuation and Repatriation Benefit	<input type="checkbox"/> \$5,000]
[Repatriation Benefit	<input type="checkbox"/> \$5,000]
[Auxiliary Member Benefit*:	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, how much?	AD&D Benefit <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000
	Medical Expense <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
	Weekly Disability <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300]
[Weekly Hospital Indemnity (per week for up to 104 weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, how much per week?	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600]
[Additional Weekly Disability (applies to 1 <sup>st</sup> week only):	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, how much?	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600]
[Organized Team Sports:	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, provide the following:	
Number of Members	Softball/Baseball/Basketball: _____ Bowling/Golf: _____
AD&D Benefit	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Medical Expense	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000
Medical Expense Deductible	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
Weekly Disability	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600
Elimination period	<input type="checkbox"/> none <input type="checkbox"/> 7 days
Duration of Benefit	<input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks]

\* Note: The Auxiliary Member Benefit and the Full Auxiliary Benefit are mutually exclusive. Either one may be included, but not both.

**PREMIUM HISTORY**

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Please indicate the Total Account Premium for the past 3 years.

Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(current year)  
Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(1<sup>st</sup> prior year)  
Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(2<sup>nd</sup> prior year)

**APPLICATION SIGNATURES & STATE FRAUD STATEMENTS**

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**NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO ARKANSAS, LOUISIANA AND NEW MEXICO APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO COLORADO APPLICANTS:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an Insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**NOTICE TO MAINE APPLICANTS:** It is a crime to provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW YORK APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**NOTICE TO PUERTO RICO APPLICANTS:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or

presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and title (please print): \_\_\_\_\_

[Insurance Broker's Signature \_\_\_\_\_] Date: \_\_\_\_\_



**ARCH INSURANCE COMPANY**  
(A Missouri Corporation)

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**POLICYHOLDER** {ABC COMPANY}  
**POLICY NUMBER** {123-45-6678899}  
**[POLICY TERM** {JANUARY 1, 2008 TO DECEMBER 31, 2008}]  
**[NAMED INSURED** { INSERT HERE}]  
**ENDORSEMENT NUMBER** {99-6678899}  
**ENDORSEMENT EFFECTIVE DATE** {JANUARY 1, 2008}

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This Endorsement is made a part of the Policy to which it is attached as of the Effective Date shown above. This form applies only to Covered Accidents that occur on or after the Effective Date. This Endorsement ends at the same time as the Policy. This Endorsement is subject to all of the provisions, terms and limitations of the Policy, excepts as they are changed by it.

[Any changes in premium apply as of the first premium due date on or after the Effective date of this Endorsement.]

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{Type Here}

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IN WITNESS WHEREOF, Arch Insurance Company has caused this Endorsement to be executed and attested.

  
\_\_\_\_\_  
Martin J. Nilsen  
Secretary

  
\_\_\_\_\_  
Mark D. Lyons  
President

*SERFF Tracking Number:* WESA-127087904      *State:* Arkansas  
*Filing Company:* Arch Insurance Company      *State Tracking Number:* 48284  
*Company Tracking Number:* ARCH-11-071  
*TOI:* H04 Health - Blanket Accident/Sickness      *Sub-TOI:* H04.000 Health - Blanket Accident/Sickness  
*Product Name:* Arch Volunteer FF Blanket Accident  
*Project Name/Number:* Arch Volunteer FF Blanket Accident/ARCH-11-071

Rate data does NOT apply to filing.

SERFF Tracking Number: WESA-127087904 State: Arkansas  
 Filing Company: Arch Insurance Company State Tracking Number: 48284  
 Company Tracking Number: ARCH-11-071  
 TOI: H04 Health - Blanket Accident/Sickness Sub-TOI: H04.000 Health - Blanket Accident/Sickness  
 Product Name: Arch Volunteer FF Blanket Accident  
 Project Name/Number: Arch Volunteer FF Blanket Accident/ARCH-11-071

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	03/22/2011

**Comments:**

Readability Certification, Consumer Information Notice, Rule 49 Appendix A, and Certificate of Compliance with Rule 19 are attached.

**Attachments:**

Readability Cert Template.pdf  
 AR ESIP Consumer Information Notice (2).pdf  
 AR ESL - Rule 49 Appendix A - 00ESL0013040311.pdf  
 Certificate of Compliance with Rule 19 (2) (2).pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	03/22/2011

**Comments:**

Application is attached.

**Attachment:**

ESIP Application.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	03/22/2011

**Bypass Reason:** N/A as this is not a PPACA filing.

**Comments:**

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Letter of Authorization	Approved-Closed	03/22/2011

**Comments:**

Letter of Authorization is attached.

**Attachment:**

*SERFF Tracking Number:* WESA-127087904      *State:* Arkansas  
*Filing Company:* Arch Insurance Company      *State Tracking Number:* 48284  
*Company Tracking Number:* ARCH-11-071  
*TOI:* H04 Health - Blanket Accident/Sickness      *Sub-TOI:* H04.000 Health - Blanket Accident/Sickness  
*Product Name:* Arch Volunteer FF Blanket Accident  
*Project Name/Number:* Arch Volunteer FF Blanket Accident/ARCH-11-071  
 Arch Volunteer Firefighter Letter of Authorization.pdf

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	03/22/2011
<b>Comments:</b> Statement of Variability is attached.		
<b>Attachment:</b> Vol FF SOV.pdf		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	03/22/2011
<b>Comments:</b> Cover Letter is attached.		
<b>Attachment:</b> ESIP Cover Letter doc AR.pdf		

## READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a combined Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Combined Flesch Score
05 VF0001 00 02 11	Blanket Insurance Policy	47.8
05 VF0002 00 03 11	Blanket Insurance Certificate	
05 VF0003 00 03 11	Endorsement	
00 VF0004 00 03 11	Accident Insurance Application	

Arch Insurance Company

\_\_\_\_\_  
Signature

Carol Kennedy  
\_\_\_\_\_  
Printed Name

Vice President, Director of Compliance  
\_\_\_\_\_  
Title

March 7, 2011  
\_\_\_\_\_  
Date

## CONSUMER INFORMATION NOTICE

You may contact Arch Insurance Company at:

One Liberty Plaza, 53<sup>rd</sup> Floor  
New York, NY 10006  
(800) 817-3252

You may contact the Arkansas Insurance Department at:

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904  
(501) 371-2600 or 1-800-282-9134

(If applicable)

You may contact your Agent at:

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**ARKANSAS NOTICE TO POLICYHOLDERS  
APPENDIX "A"**

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

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
425 West Capitol Avenue, Suite 3700  
Little Rock, AR 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

## COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net

cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1, 000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**Arch Insurance Company**

Home Office: 3100 Broadway, Suite 511, Kansas City, MO 64111  
Administrative Office: 300 - Plaza Three, 3rd Fl., Jersey City, NJ 07311

**CERTIFICATE OF COMPLIANCE**

I certify that the attached submission meets the provisions of Rule 19 as well as all applicable requirements of the Arkansas Insurance Department.



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Dated: March 18, 2011



[Administrative Address:  
One Liberty Plaza,  
53rd Floor  
New York, NY 10006  
(800) 817-3252]

**GENERAL INFORMATION**

Date of survey: \_\_\_\_\_ Renewal Date: \_\_\_\_\_ Date proposal needed: \_\_\_\_\_

Legal Name of Organization: \_\_\_\_\_  
(Include all organizations that are to be included as insureds including Fire Districts, Fire Companies, Rescue Squads and Auxiliaries)

FEIN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
County: \_\_\_\_\_

Website Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Chief: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Training Officer: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Inspection Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**INSURANCE AGENT INFORMATION**

Producer: \_\_\_\_\_ CSR or Other Contact \_\_\_\_\_

Name of Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Do you currently write this account?  Yes  No

If yes, for how long? \_\_\_\_\_ Carrier Name? \_\_\_\_\_

Is the account Sub-Brokered?  Yes  No

If yes, please indicate Agency Name and Address: \_\_\_\_\_

**BUSINESS INFORMATION**

Which best describes the organization (please check one):

- Fire Suppression only (no EMS)
- Fire and Rescue/EMS
- Rescue/EMS Squad or Ambulance Squad
- Other (please describe): \_\_\_\_\_

The organization is a (please check one):

- Tax District
- Independent Non-Profit Organization
- Municipal, Village or Town Department
- Other (please describe): \_\_\_\_\_

If a municipal, village or town department, is the organization a separate legal entity?  Yes  No

Population served on a first-call basis: \_\_\_\_\_ Years in operation: \_\_\_\_\_

Have you been Cancelled, Non-Renewed, Declined, or Cancelled in the past 3 years?  Yes  No

If Yes, Please Explain: \_\_\_\_\_

## OPERATIONS INFORMATION

Total Population Served on a First Call Basis: \_\_\_\_\_

Total number of emergency responses (excluding Mutual Aid) in the past twelve months (please attach a call-log if available):

Total Fire \_\_\_\_ Total Rescue \_\_\_\_ Total EMS \_\_\_\_

Does the organization service a major highway?  Yes  No

If yes, approximately how many rescue calls can be attributed to this service? \_\_\_\_\_

Does the organization service a resort area?  Yes  No

If yes, approximately how much does the population increase during peak season? \_\_\_\_\_

Total number of Volunteers, including Junior Members and Auxiliary Members: \_\_\_\_\_

Are all Volunteers currently covered by Workers Compensation Insurance?  Yes  No

Total number of Career (Paid) Personnel (works more than 750hrs annually): \_\_\_\_\_

Are all Career (Paid) Personnel currently covered by Workers Compensation Insurance?  Yes  No

Does the organization... (Please check all that apply)

Have a designated safety officer? Name: \_\_\_\_\_

Have a safety committee?

Require a minimum of 8 hours of safety training annually?

Require annual physicals for its members?

Have organized health and wellness initiatives (i.e. fitness program)?

Have and enforce a seatbelt policy?

Have an organized driver training program?

Utilize an incident command system on every call?

Require annual mask fit tests?

Have a safe lifting training program?

Have annual blood-borne pathogen training requirements?

Have power cots?

Have a policy and enforce the use of universal precautions?

Requires all officers be at least NIMS 200 certified?

Require all firefighters be least firefighter level 1 trained?

Hold any special events? Please describe: \_\_\_\_\_

## ACCIDENT PROGRAM BENEFITS

[Core Benefits	Select the Benefit Limits to be Included (choose one in each category)				
	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 5
Indemnity Benefits					
Accidental Death & Dismemberment	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Illness Loss of Life	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Physical Impairment – Injury	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Physical Impairment – Illness	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Permanent Cardiac Impairment	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Burn Disfigurement	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
HIV	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000
Blanket Medical Expense	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000				
Weekly Disability Benefit (Week 1- 4 / Week 5+)	<input type="checkbox"/> \$100/\$200 <input type="checkbox"/> \$200/\$400 <input type="checkbox"/> \$300/\$600 <input type="checkbox"/> \$400/\$800 <input type="checkbox"/> \$500/\$1,000 <input type="checkbox"/> \$600/\$1,200				
Accidental Death & Dismemberment – Other than Covered Activity	<input type="checkbox"/> 24-Hour Coverage (includes Line of Duty) <input type="checkbox"/> Off Duty Coverage <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000				
Athletics & Special Events – Injury Only	Medical Expense <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 Total Disability – Per Week <input type="checkbox"/> \$100 <input type="checkbox"/> \$200				

**Additional Core Benefits** (included with Core benefits selected above – note that if indemnity, medical expense and weekly disability benefits are not all selected, not all of these benefits may apply)

[Additional Seatbelt Benefit – Injury Only	25% of Principal Sum]
[Post-Traumatic Stress Disorder	\$20,000]
[HIV Infection Prevention	\$3,500]
[Family Expense Benefit	\$25,000]
[Family Education Benefit	\$5,000]
[Plastic Surgery	\$10,000]
[Preventive Inoculations	\$10,000]
[Physical Assault Benefit – Injury Only	25% of Principal Sum]
[Day Care Expense Benefit	up to \$30 per day for up to 26 weeks]
[Permanent Physical Impairment Education	35% of Permanent Physical Impairment Benefit, not to exceed \$20,000]
[Continuation of Coverage – Injury Only	up to \$500 per month for 18 months, not to exceed \$6,000]
[Residence and Vehicle Adaptation Expense	\$15,000]
[Burial and Cremation	10% of Principal Sum, not to exceed \$5,000]
[Survivor (Child, Spouse or Domestic Partner, Elder)	10% of Principal Sum, not to exceed \$5,000]
[Critical/Traumatic Incident Stress Management Team	\$20,000]
[Transition Benefit	Weekly Disability Benefit for up to an additional 26 weeks]

**Optional Benefits** (select the optional benefits to be included)

[Career Personnel (Career Personnel will receive same benefits selected for Volunteers):	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[Full Auxiliary* (Auxiliary Members will receive same benefits selected for Volunteers):	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[Emergency Evacuation and Repatriation Benefit	<input type="checkbox"/> \$5,000]
[Repatriation Benefit	<input type="checkbox"/> \$5,000]
[Auxiliary Member Benefit*:	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, how much?	AD&D Benefit <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000
	Medical Expense <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
	Weekly Disability <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300]
[Weekly Hospital Indemnity (per week for up to 104 weeks):	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, how much per week?	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600]
[Additional Weekly Disability (applies to 1 <sup>st</sup> week only):	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, how much?	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600]
[Organized Team Sports:	<input type="checkbox"/> Yes <input type="checkbox"/> No
• If Yes, provide the following:	
Number of Members	Softball/Baseball/Basketball: _____ Bowling/Golf: _____
AD&D Benefit	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Medical Expense	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000
Medical Expense Deductible	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
Weekly Disability	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600
Elimination period	<input type="checkbox"/> none <input type="checkbox"/> 7 days
Duration of Benefit	<input type="checkbox"/> 26 weeks <input type="checkbox"/> 52 weeks]

\* Note: The Auxiliary Member Benefit and the Full Auxiliary Benefit are mutually exclusive. Either one may be included, but not both.

**PREMIUM HISTORY**

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Please indicate the Total Account Premium for the past 3 years.

Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(current year)  
Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(1<sup>st</sup> prior year)  
Carrier(s): \_\_\_\_\_ \$ \_\_\_\_\_  
(2<sup>nd</sup> prior year)

**APPLICATION SIGNATURES & STATE FRAUD STATEMENTS**

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**NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO ARKANSAS, LOUISIANA AND NEW MEXICO APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO COLORADO APPLICANTS:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an Insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**NOTICE TO MAINE APPLICANTS:** It is a crime to provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW YORK APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**NOTICE TO PUERTO RICO APPLICANTS:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or

presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name and title (please print): \_\_\_\_\_

[Insurance Broker's Signature \_\_\_\_\_] Date: \_\_\_\_\_



[www.archinsurance.com](http://www.archinsurance.com)

Arch Insurance Group  
300 – Plaza Three  
Jersey City, NJ 07311-1107

T 201.743.4000  
F 201.743.4005

March 1, 2011

Arch Insurance Company  
Filing Designation #ARCH-11-071  
FEIN#: 43-0990710  
NAIC#: 1279 11150

Letter of Authorization  
Filing of Forms, Rates and Rules

Dear Sir or Madame:

In accordance with the applicable statutes and regulations in your state, Darcy Lebau and Westmont Associates are hereby authorized to file form, rate and rate filings on behalf of Arch Insurance Company.

Very truly yours,

Carol Kennedy  
Vice President & Director of Compliance

## **Arch Insurance Company**

### **Statement of Variables Blanket Insurance Policy (Form #) and related forms**

Please note variable information is contained in brackets. In no event will the information contained in these brackets be less favorable to an insured than the minimum standards set forth in your law.

Please note the following general comments regarding variable information.

#### **General Statement**

The Policyholder, Policy Number, Policy Effective Date, Policyholder Address, Policy Term and Policy Anniversary Date are variable. They will reflect the information unique to each Policyholder.

#### **Policy & Certificate Schedule Pages**

We have illustrated the policy and certificate schedules. Variations will occur based on the nature of the group, the classes covered, the benefits offered and the applicability of certain provisions at either the case, class or benefit level. We consider any benefits, amounts, deductibles, co-payments, benefit durations, dates or application of benefits to be completely variable unless your law requires a limitation.

#### **Eligible Persons**

We intend to market this form to the following groups: volunteers, auxiliary, career personnel, municipalities or out-of-state trusts. Therefore, the description of eligible class may vary based on the nature of the group and classes covered. References to members of a group throughout the forms may vary accordingly, i.e. employee, member, participant, etc.

#### **Effective Date Provisions**

Generally, coverage will be offered on a non-contributory blanket basis. However, we may also provide coverage or supplemental coverage on a contributory or voluntary basis. In these circumstances the text used would vary based on premium sources, the method of enrollment and the plans available. In some cases, it may be necessary to distinguish effective dates for each type of plan. For example, any coverage paid for by the Policyholder is effective immediately upon becoming eligible; whereas, any coverage for which the member pays premium is effective at a time after the required enrollment form and premium are received.

#### **Combined Benefits**

This policy is designed to provide accident benefits only. It may also be used to support the offering of accidental death and dismemberment (AD&D) benefits only or AD&D and accident medical expense benefits only. All of the benefits and provision that apply to a policyholder may be included in the policy and certificate text when first issued. If any of the benefits or provisions become applicable after the initial effective date of coverage they will be issued as an endorsement.

#### **Certificates**

The content and format of certificates may vary in any of the following respects:

- a. Separate certificates may be issued for each of the classes eligible under the policy. In this case,

any wording that does not relate to the rights or obligations of that class of insured may be omitted.

- b. Any wording that solely relates to the rights and obligations of the policyholder may be omitted.
- c. Connective words and phrases that only serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other substantive terms or conditions of the policy affecting the insurance provided may vary. This variation will occur as required to ensure the readability of the form where other variable material is changed. These wording changes will not be ambiguous or deceptive.
- d. The order and grouping of provision may be modified. References to information contained on the certificate schedule may be expressed in the text of the provision as it relates to a particular class of insureds.
- e. The print size, style, page size and layout may be modified to reflect various formats including 8.5x11 pages, booklet pages or brochure styles subject to the print and other requirements of your readability law.
- f. Specific rates may be omitted or replaced with reference to the rates currently in force.
- g. The inclusion of certain provisions and their wording may vary to meet the specifications of the product requested by our customers or to clarify the administration of the policy or other items as requested by our policyholders.
- h. Wording may be changed to comply with future changes in your laws or regulations impacting the policy, or in the laws of the states where certificates under the policy are delivered.

**Schedule of Benefits**

Policyholder, Policy Number, Policy Effective Date, Policy Termination Date and Premium Due Date are variable. They will reflect the information unique to each Policyholder.

The Policyholder selects which of the following classes are covered.

[Class 1 Volunteers]

[Any officially designated member in good standing of the Policyholder, including 1) Volunteer members or volunteer members who receive nominal fees as retainers; 2) registered junior members; 3) any director, commissioner, trustee, board member, officer of the board, or holder of a similar position; 4) part time employees of the Policyholder with no more than 1,300 hours annually; and 5) any bystander deputized by an official of the Policyholder at the scene of an emergency to assist at the emergency, but only until the emergency ends. Eligibility does not include a paid employee of the Policyholder who works more than 1,300 hours annually for the Policyholder and who is acting within the scope of his employment.]

[Class 2 Auxiliary]

[A member of the Policyholder's auxiliary organization by whatever name called and 1) any person while assisting the auxiliary organization if requested to do so by an officially designated member in good standing of the Policyholder or the Policyholder's auxiliary organization and 2) any person while assisting the Policyholder if requested to do so by an officially designated member in good standing of the Policyholder.]

[Class 3 Career Personnel]

[A paid employee of the Policyholder who works more than 1,300 hours for the Policyholder and who is acting within the scope of his employment.]

Premiums are determined based on the plan design selected by the Policyholder

The summary of benefits only provides the following benefits with a specified amount entered in the amount of insurance column across from the name of the benefit. If there is no entry, or an entry of \$0, or none, then the benefit is not provided under the policy.

<u>BENEFITS</u>	<u>AMOUNT OF INSURANCE</u>
<b>Part I – Indemnity Benefits</b>	

A. Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing – Injury Only	Principal Sum: \$1,000 - \$1,000,000
B. Additional Loss of Life – Illness Only	Principal Sum: \$1,000 - \$1,000,000
C. Additional Seat Belt Benefit – Injury Only	Maximum:\$500- \$500,000
D. Post Traumatic Stress Disorder	Maximum:\$500- \$500,000
<b>Part II – Permanent Physical Impairment Benefit – Injury Only</b>	Principal Sum: \$1,000 - \$1,000,000
<b>Part III – Permanent Physical Impairment Benefit – Illness Only</b>	Principal Sum: \$1,000 - \$1,000,000
<b>Part IV – Weekly Disability Permanent Physical Impairment Benefit – Injury Only</b>	Per Week: \$100 - \$2,500
<b>Part V–Cosmetic Burn Disfigurement Benefit – Injury Only</b>	Principal Sum: \$1,000 - \$1,000,000
<b>Part VI – Permanent Cardiac Impairment Benefit – Illness Only</b>	Maximum: \$1,000 - \$1,000,000
<b>Part VII – Medical Expense Benefits – Injury Only</b>	
A. Medical Expense	Maximum: \$1,000 - \$1,000,000
B. Plastic Surgery	Maximum: \$1,000 - \$100,000
<b>Part VIII – Medical Expense Benefits – Illness Only</b>	
A. Medical Expense	Maximum: \$1,000 - \$1,000,000
B. Preventive Inoculations	Maximum: \$1,000 - \$50,000
<b>Part IX – Weekly Disability Benefit – Injury Only</b>	
A. Total Disability	Per Week: \$100 - \$2,500
B. Partial Disability	Per Week: \$100 - \$2,500
<b>Part X – Weekly Disability Benefit – Illness Only</b>	
A. Total Disability	Per Week: \$100 - \$2,500
B. Partial Disability	Per Week: \$100 - \$2,500
<b>Part XI – Family Expense Benefit – Injury or Illness</b>	Maximum: \$500 - \$100,000
<b>Part XII – Family Education Benefit – Injury or Illness</b>	
A. Dependent Child	Maximum: \$500 - \$50,000
B. Surviving Spouse	Maximum: \$500 - \$50,000
C. Other	Maximum: \$500 - \$50,000
<b>Part XIII – Athletic and Special Events Benefits – Injury Only</b>	
A. Medical Expense	Maximum: \$1,000 - \$1,000,000
B. Total Disability	Per Week: \$100 - \$2,500
<b>Part XIV – HIV Benefit</b>	
A. HIV Lump Sum	Maximum: \$1,000 - \$1,000,000
B. HIV Infection Prevention	Maximum: \$1,000 - \$50,000
<b>Part XV – Physical Assault Benefit – Injury Only</b>	Maximum: \$500 - \$100,000
<b>Part XVI – Day Care Expense Benefit – Injury or Illness</b>	Household Maximum (per Day):\$25 - \$200 Up to a Maximum of: 26 -52 weeks

<b>Part XVII – Permanent Physical Impairment Education Benefit – Injury Only</b>	35% of Permanent Physical Impairment Benefit Maximum: \$1,000 - \$100,000
<b>Part XVIII – Residence and Vehicle Adaptation Expense Benefit</b>	Maximum:\$500- \$500,000
<b>Part XIX – Continuation of Coverage Benefit – Injury Only</b>	Per Month: \$100 - \$1,000 Maximum: \$1,200 - \$12,000
<b>Part XX – Accidental Death and Dismemberment Benefit – Injury Only (Extension to 24-Hour Coverage)</b>	
A. Loss of Life	Principal Sum: \$1,000 - \$1,000,000
B. Dismemberment Loss as listed under Part I ‘A’ Description of Benefits	We will pay the % listed of the Principal Sum payable for Loss of Life under this Part XVI Maximum: \$500 - \$1,000,000
C. 24 Hour Accidental Death and Dismemberment	Principal Sum: \$1,000 - \$1,000,000
<b>Part XXI – Burial and Cremation Benefit</b>	Maximum: \$500 - \$200,000
<b>Part XXII – Survivor Benefits</b>	
A. Dependent Child	Maximum: \$500 - \$100,000
B. Surviving Spouse	Maximum: \$500 - \$100,000
C. Elder	Maximum: \$500 - \$100,000
<b>Part XXIII – Transition Benefit Per Week</b>	Maximum:\$100- \$5000
<b>Part XXIV – Critical/Traumatic Incident Stress Management Team Benefit</b>	Maximum: \$1,000 - \$1,000,000
<b>Part XXV Emergency Medical Evacuation [and Repatriation] Benefit</b>	Principal Sum: \$1,000 - \$1,000,000
<b>Part XXVI Repatriation Benefit</b>	Principal Sum: \$1,000 - \$1,000,000
<b>Part XXVII Optional Benefits</b>	
A. Additional Weekly Disability Benefit	Per Week: \$100 - \$2,500
B. Weekly Hospital Indemnity Benefit	Per Week: \$100 - \$5,000
C. Auxiliary Member Benefit	
a. Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing – Injury Only	Maximum: \$1,000 - \$1,000,000
b. Medical Expense – Injury Only	Maximum: \$1,000 - \$1,000,000
c. Total Disability – Injury Only	Per Week: \$100 - \$2,500
D. Organized Team Sports Benefit	
a. Accidental Death, Dismemberment, Loss of Sight, Speech or Hearing – Injury Only	Maximum: \$1,000 - \$1,000,000
b. Medical Expense – Injury Only	Maximum: \$1,000 - \$1,000,000
c. Total Disability – Injury Only	Per Week: \$100 - \$2,500

**Description of Benefits**

The Description of Benefits explain the benefits available under the Policy. All benefits payable are shown in the Schedule of Benefits. All definitions that appear in the Description of Benefits will also appear in the Definitions

Section. Variable text is defined in brackets and outlined below:

- Additional Loss of Life Benefit – Illness Only - death occurs within 90 - 180 days of the date the Covered Person participated in the Covered Activity that caused such death.
- Additional Seat Belt Benefit – Injury Only - If the loss of life benefit is payable under “A”, We will pay an additional 10% - 25% of the Principal Sum if the Covered Person was in a motor vehicle and wearing a properly fastened seat belt when the Injury occurred that caused death.
- Permanent Physical Impairment Benefit – Injury Only - If no election is made within the Period of Eligibility, We will notify the Covered Person; and the Period of Eligibility will be extended an additional 45 - 90 days. If the Covered Person does not notify Us by registered mail of the election to accept the payment under this benefit prior to the expiration of the 45 - 90 -day extension period, the Covered Person will lose the right to claim this benefit. However, under no circumstances will We pay a benefit under this Part II if We are notified of the Covered Person’s election to accept the benefit more than 130 - 260 weeks after the date of the Injury that caused the Permanent Physical Impairment, even if such notification is received during the period of eligibility or the 90 day extension period described above. The benefit will be [75%, 100% or 125% of the Principal Sum].
- Permanent Cardiac Impairment Illness Only– resulted in at least 26 - 39 weeks. The Covered Person had a Left Ventricular Ejection Fraction greater than 20% – 35% prior to the date of the Covered Activity. The Covered Person’s highest Left Ventricular Ejection Fraction (LVEF) and lowest New York Heart Association (NYHA) Functional Classification ratings will be obtained not more than 6 - 12 months after the Covered Activity that caused the heart condition. Medical Expense Illness Only - Medical Expense – If Illness begins within 10, 20 or 30 days of the date of Covered Person’s participation in the Covered Activity. Preventative Inoculations – We will pay the Reasonable and Customary Expense incurred for preventative inoculations received within 15, 30, 45 or 60 days of the date of a Covered Person’s participation in a Covered Activity that caused exposure to a Illness including any additional expenses due to an allergic reaction to any preventative inoculations administered to the Covered Person subject to the Maximum Benefit shown in the Schedule.
- Weekly Disability Benefit – Injury Only/Total Disability Benefit - pay the full weekly benefit shown in the Schedule for each week of the first 2, 4 or 6 weeks of Total Disability. After the first 2, 4 or 6 weeks of Total Disability, We will pay up to twice the weekly benefit shown in the Schedule, but not more than 100% of the Covered Person’s Average Weekly Wage for such continued disability. In no event will We pay a benefit that is less than 20 - 35% of the weekly benefit shown in the Schedule for continued Total Disability. Total Disability Inflation Provision – After the first 1- 3 years of Total Disability for which We have paid benefits, We will increase additional benefits paid for that Total Disability. We will increase the benefit by 2% - 3% (compounded annually) for each additional year the Covered Person continues to be eligible for Total Disability benefits.
- Weekly Disability Benefit – Injury Only/Partial Disability Benefit - If the Partial Disability is the direct result of the Covered Person’s participation in a Covered Activity, We will pay 50% of the weekly benefit shown in the Schedule for each of the first 2, 4 or 6 weeks of Partial Disability. If the Partial Disability is immediately following a period of Total Disability for which a benefit was paid under “A”, We will pay up to 50% of the weekly benefit shown in the Schedule but not more than 50% of the Covered Person’s Average Weekly Wage for each of the first 2, 4 or 6 weeks of Partial Disability. After the first 2, 4 or 6 weeks of Partial Disability, We will pay up to the full weekly benefit shown in the Schedule but no more than 50% of the Covered Person’s Average Weekly Wage. In no event will We pay less than 10%, 12.5% or 17.5% of the weekly benefit shown in the Schedule. Benefits for Total Disability as a result of any one Injury will not be paid for more than 5 years, 10 years; or the lifetime of the Covered Person. Benefits for Partial Disability will not be paid for more than 52 - 104 weeks as a result of any one Injury. Periods of Total Disability or Partial Disability separated by less than 13-26 weeks will be considered one period of disability unless due to separate and unrelated causes.
- Weekly Disability Benefit – Illness Only/Total Disability Benefit – Pay full weekly benefit each week for the first 2, 4 or 6 weeks of Total Disability. After the first 2,–4 or 6 weeks of Total Disability, We will pay up to twice the weekly benefit shown in the Schedule, but not more than 100% of the Covered Person’s Average Weekly Wage for such continued disability. In no event will We pay a benefit that is less than 25% - 30% of the weekly benefit shown in the Schedule for continued Total Disability. Total Disability

Inflation Provision – After the first 1 - 3 years of Total Disability for which We have paid benefits, We will increase additional benefits paid for that Total Disability. We will increase the benefit by 2% - 3% (compounded annually) for each additional year the Covered Person continues to be eligible for Total Disability benefits. Weekly Disability Benefit – Illness Only/Partial Disability Benefit - If the Partial Disability is the direct result of the Covered Person's participation in a Covered Activity, We will pay 50% - 100% of the weekly benefit shown in the Schedule for each of the first 2, 4 or 6 weeks of Partial Disability. If the Partial Disability is immediately following a period of Total Disability for which a benefit was paid under "A", We will pay up to 50% - 100% of the weekly benefit shown in the Schedule but not more than 50% of the Covered Person's Average Weekly Wage for each of the first 4- 8 weeks of Partial Disability. After the first 4-8 weeks of Partial Disability, We will pay up to the full weekly benefit shown in the Schedule but no more than 50%-100% of the Covered Person's Average Weekly Wage. In no event will We pay a benefit less than 12.5% - 15% of the weekly benefit shown in the Schedule. Benefits for Total Disability as a result of any one Illness will not be paid for more than [260, 250, or 260 weeks or to age 67] or [whichever is longer. Partial Disability will not be paid for more than 26 -52 weeks. Periods of Total Disability or Partial Disability separated by less than 4-26 weeks will be considered one period of disability unless due to separate and unrelated causes. [In no event will benefits be paid for more than 52-260 weeks for Total Disability and Partial Disability as a result of any one Illness].

- Family Expense Benefit – [Injury] [or] [Illness] - We will also pay the following additional benefits for the Reasonable and Customary Expenses incurred on behalf of the Covered Person within 26-52 weeks of the date of Injury or Illness. transportation, meals and lodging expenses of the Immediate Family members incurred for visiting the Covered Person if he is receiving medical treatment on an inpatient basis more than 35 - 50 miles from the Covered Person's permanent residence.
- Family Education Benefit - under age 21 and enrolls as a full time student at an Institution of Higher Learning above the 12<sup>th</sup> grade level within 24 - 36 months of the date of the Covered Person's death. We will pay the annual tuition actually incurred at an Institution of Higher Learning, excluding room and board, by the Surviving Spouse of the deceased Covered Person. This benefit is payable only if the surviving spouse enrolls in an Institution of Higher Learning within 48 - 60 months of the date of the Covered Person's death. We will pay up to the Maximum Benefit shown in the Schedule for this benefit for each year the Surviving spouse is enrolled at such institution, for up to 2-4 consecutive years. If no person qualifies for the benefits, We will pay a benefit of \$2,500, \$5,000 or \$10,000 to the Covered Person's primary beneficiary. If no beneficiary is named We will pay the amount to the Covered Person's estate. We will not pay more than a total benefit of \$2,500, \$5,000 or \$10,000 under this benefit.
- Athletics and Special Events Benefit – Injury Only - We will pay the weekly benefit for this benefit "B" if the Covered Person becomes Totally Disabled within 20, 30, 45 or 60 days after the date of Injury. For any Total Disability benefit paid for less than a week, We will pay one-seventh (1/7) of the weekly benefit for each full day the Covered Person is disabled up to the applicable maximum. We will pay up to a maximum of 26 - 52 weeks for any one accident.
- HIV Benefit - The incident report described in (2) above is filed with Us within 3, 5 or 7 days of the date that it was filed with the Policyholder; and the Covered Person is tested for the presence of HIV antibodies in their blood within 3, 5 or 7 days of the date such report was filed with Us, and, must test negative utilizing a preliminary screening test approved by the Federal Food & Drug Administration (FDA); and the Covered Person tests positive for the presence of HIV antibodies in their blood within 26-52 weeks of participation in the Covered Activity during which the Covered Person was exposed to HIV utilizing a positive screening test approved by the FDA.
- Physical Assault Benefit – Injury Only - If a benefit is payable for Injury under Part I, Part II or Part III of the Policy, We will pay an additional benefit equal to 25% - 50% of the total benefit paid under such Part I, Part II or Part III, or the Maximum shown in the Schedule for this Part XIII, whichever is more, if such Injury is caused by Physical Assault committed by a person other than an Covered Person, while traveling to or from emergency duty or while at the emergency duty.
- Permanent Physical Impairment Education - We will not pay this benefit for any tuition incurred by the Covered Person more than 156 - 260 weeks after the end of the Period of Eligibility. We will not pay more than the Maximum shown in the Schedule.
- Residence and Vehicle Adaptation Benefit - the Residence and Vehicle Adaptation Expenses are

incurred within 12 - 24 months of the Covered Activity that caused the Injury or Illness.

- Continuation of Coverage - We will pay the cost of group medical insurance coverage up to a maximum of \$100 - \$1,000 per month for up to a total maximum of \$1,200 - \$12,000, not to exceed 18 - 24 months.
- Burial and Cremation Benefit – We will pay the cost of burial or cremation expenses.
- Transition Benefit – We continue to pay disability benefits in the event that the employer terminates employment for up to an additional 26 weeks.
- Critical/Traumatic Incident Stress Management Team Benefit – We will pay for critical stress managements services requested by the Policyholder and are required as the result of a Covered Accident.
- Emergency Medical Evacuation and Repatriation Benefit – We will pay transportation expenses for a Covered Person to receive medical services.
- Repatriation Benefit – We will pay to return the remains of a Covered Person.
- Optional Benefits - Weekly Hospital Indemnity - We will not pay for more than 104 - 260 weeks as a result of any one Injury or Illness.

### **Exclusions**

Exclusions are variable and may be deleted based on the plan of benefits selected by the Policyholder. Any bracketed exclusion and any bracketed text within an exclusion may be included or omitted from the Policy.



**WESTMONT  
ASSOCIATES, INC.**

March 18, 2011

via SERFF

The Honorable Julie Benafield Bowman  
Commissioner of Insurance  
Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
*Attention: Life & Health Division*

**RE: Arch Insurance Company  
Filing Designation # ARCH-11-071  
FEIN#: 43-0990710  
NAIC#: 1279 11150  
Blanket Accident Product Forms  
Blanket Insurance Policy Form # 05 VF0001 00 02 11  
Blanket Insurance Certificate Form # 05 VF0002 00 03 11  
Endorsement Form # 05 VF0003 00 03 11  
Accident Insurance Application Form # 00 VF0004 00 03 11**

Honorable Commissioner Bowman:

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

The Blanket Accident Policy, Form #05 VF0001 00 02 11, provides accident benefits to eligible blanket groups comprising of volunteer firefighters and emergency services personnel only. Arch files these forms as variable, offering accidental death and dismemberment benefits and additional benefits triggered by an accident resulting from a covered injury either separately or in combination on a non-contributory basis.

As the policyholder will select the benefits for its group, only the benefits and dollar amounts will vary. Variable data is bracketed and may vary on a case basis. Please see the enclosed Statement of Variability for Arch's explanation of how this data may vary. This product will be marketed by licensed producers and brokers to eligible groups.

In accordance with Arkansas' filing requirements, enclosed please find:

- Readability Certification
- Letter of Authorization

- Forms
- Statement of Variability
- Certificate of Compliance
- Rule 49 Appendix A
- Consumer Information Notice

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

Respectfully,

*Darcy Lebau*

Darcy Lebau