

<i>SERFF Tracking Number:</i>	<i>ZURC-127070621</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Zurich American Insurance Company</i>	<i>State Tracking Number:</i>	<i>48289</i>
<i>Company Tracking Number:</i>	<i>CW AH 32050</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death & Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death & Dismemberment</i>
<i>Product Name:</i>	<i>Group Accident Policy - New Optional Riders</i>		
<i>Project Name/Number:</i>	<i>/CWAH 32050</i>		

Filing at a Glance

Company: Zurich American Insurance Company

Product Name: Group Accident Policy - New Optional Riders SERFF Tr Num: ZURC-127070621 State: Arkansas

Optional Riders

TOI: H03G Group Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved-Closed State Tr Num: 48289

Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment Co Tr Num: CW AH 32050 State Status: Approved-Closed

Filing Type: Form

Author: Karen Falbo

Date Submitted: 03/21/2011

Reviewer(s): Rosalind Minor

Disposition Date: 03/22/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name:

Project Number: CW AH 32050

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Association, Other

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 03/10/2011

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

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

Overall Rate Impact:

Filing Status Changed: 03/22/2011

State Status Changed: 03/22/2011

Deemer Date:

Submitted By: Karen Falbo

Created By: Karen Falbo

Corresponding Filing Tracking Number:

Filing Description:

The purpose of this filing is to seek approval of new riders for use with our Group Accident Policy, U-GMC-100. The Group Accident Policy was filed and approved in your state, under Company Tracking Number CW AH 29266 and State Tracking Number: 44163.

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These riders are new and not intended to replace any other form currently in use.

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$600.00
 Retaliatory? No
 Fee Explanation: Filing or review of life and health policy/contracts, endorsements, certificate, riders, applications or annuity forms, per form...\$50.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Zurich American Insurance Company	\$600.00	03/21/2011	45799391

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Dismemberment Dismemberment
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Correspondence Summary

Dispositions

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

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanatory	Approved-Closed	Yes
Supporting Document	Statement of Variables	Approved-Closed	Yes
Form	Accident Weekly Indemnity Benefit	Approved-Closed	Yes
Form	Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage for Dependent Children	Approved-Closed	Yes
Form	[Out of Country] Accident Excess Corridor Medical Expense Benefit	Approved-Closed	Yes
Form	Catastrophe Cash Benefit	Approved-Closed	Yes
Form	Coma Benefit	Approved-Closed	Yes
Form	Emergency Treatment Benefit	Approved-Closed	Yes
Form	Funeral Expense Benefit	Approved-Closed	Yes
Form	In-Hospital Indemnity Benefit	Approved-Closed	Yes
Form	Policyholder Sponsored Activity Benefit	Approved-Closed	Yes
Form	Terrorism Benefit	Approved-Closed	Yes
Form	Travel Assistance Coverage	Approved-Closed	Yes
Form	Accidental Dismemberment [and Covered Loss of Use] [and Plegia] Coverage	Approved-Closed	Yes

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Form Schedule

Lead Form Number: U-GMC-117

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/22/2011	U-GMC-117-A CW (01/11)	Policy/Cont	Accident Weekly ract/Fratern Indemnity Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		34.000	U-GMC-117-A CW - Accident Weekly Indemnity Benefit.pdf
Approved-Closed 03/22/2011	U-GMC-119-A CW (01/11)	Policy/Cont	Accidental ract/Fratern Dismemberment [and al Covered Loss of Certificate: Use] [and Plegia] Amendmen Coverage for t, Insert Dependent Children Page, Endorseme nt or Rider	Initial		59.000	U-GMC-119-A CW - Ax Dsmbr Loss of Use Coverage for Dependent Children.pdf
Approved-Closed 03/22/2011	U-GMC-122-A CW (01/11)	Policy/Cont	[Out of Country] ract/Fratern Accident Excess al Corridor Medical Certificate: Expense Benefit Amendmen t, Insert Page, Endorseme nt or Rider	Initial		36.000	U-GMC-122-A CW - Excess Corridor AME Benefit.pdf
Approved-Closed 03/22/2011	U-GMC-125-A CW (01/11)	Policy/Cont	Catastrophe Cash ract/Fratern Benefit al	Initial		44.000	U-GMC-125-A CW - Catastrophe

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<i>Project Name/Number:</i>	<i>/CWAH 32050</i>		
	Certificate:		Cash
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	Page,		
	Endorseme		
	nt or Rider		
Approved- U-GMC- Closed 127-A CW 03/22/2011 (01/11)	Policy/Cont Coma Benefit ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.000
			U-GMC-127- A CW - Coma Benefit.pdf
Approved- U-GMC- Closed 129-A CW 03/22/2011 (01/11)	Policy/Cont Emergency ract/Fratern Treatment Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	43.000
			U-GMC-129- A CW - Emergency Treatment Benefit.pdf
Approved- U-GMC- Closed 130-A CW 03/22/2011 (01/11)	Policy/Cont Funeral Expense ract/Fratern Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51.000
			U-GMC-130- A CW - Funeral Expense Benefit.pdf
Approved- U-GMC- Closed 132-A CW 03/22/2011 (01/11)	Policy/Cont In-Hospital Indemnity ract/Fratern Benefit al Certificate:	Initial	45.000
			U-GMC-132- A CW - In- Hospital Indemnity

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<i>Project Name/Number:</i>	<i>/CWAH 32050</i>		
	Amendmen t, Insert Page, Endorseme nt or Rider		Benefit.pdf
Approved- Closed 03/22/2011	U-GMC- 135-A CW (01/11)	Policy/Cont ract/Fratern al Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 45.000
			U-GMC-135- A CW - Policyholder Sponsored Activity Benefit.pdf
Approved- Closed 03/22/2011	U-GMC- 136-A CW (01/11)	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 43.000
			U-GMC-136- A CW - Terrorism Benefit.pdf
Approved- Closed 03/22/2011	U-GMC- 137-A CW (01/11)	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 43.000
			U-GMC-137- A CW - Travel Assistance Coverage.pdf
Approved- Closed 03/22/2011	U-GMC- 146-A CW (01/11)	Policy/Cont ract/Fratern al Covered Loss of Certificate: Use] [and Plegia] Amendmen Coverage	Initial 58.000
			U-GMC-146- A CW - Ax Dsmbr Loss of Use Coverage.pdf

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ZURICH®

Accident Weekly Indemnity Benefit

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [an **Insured**] [a **Covered Person**] suffers a **Covered Injury**, which renders him or her **Totally Disabled**, **We** will pay an Accident Weekly Indemnity Benefit provided:

1. the **Total Disability** occurs within [thirty (30)] days of the date of the **Covered Injury**;
2. the [**Insured**] [**Covered Person**] has satisfied the **Benefit Waiting Period**; and
3. the [**Insured**] [**Covered Person**] is being attended to by a duly licensed **Physician**.

Payments will begin on the first day after the **Benefit Waiting Period** and will continue for as long as the [**Insured**][**Covered Person**] is **Totally Disabled**, but will not exceed the **Benefit Period** of [fifty-two (52) weeks]. The amount of the payments will be equal to the amount shown on the Schedule [reduced by [(1) Workers' Compensation Disability Benefit]; [(2) Social Security Disability Benefits excluding any amounts for which the **Insured's Dependents** may qualify because of the **Insured's** disability]; [(3) Social Security Retirement Benefits]; [(4) Group Disability Benefits]; [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance]].

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

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

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

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

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

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

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

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

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



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

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

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

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

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

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

on one side of the body)

[25%] to a maximum of \$[50,000]]

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

[12.5%] to a maximum of \$25,000]]

For purposes of this rider only:

Covered Loss means:

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

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

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

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

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

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

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

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

[Out of Country] Accident Excess Corridor Medical Expense Benefit



Zurich American Insurance Company
 1400 American Lane
 Schaumburg, Illinois 60196

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

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

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

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

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

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

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

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

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

9. The services of a registered nurse not **Related** to the **[Insured] [Covered Person]**.
10. Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
11. Outpatient laboratory test expenses.
12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12]] visits. Expenses include treatment and office visits connected with such treatment when prescribed by a **Physician**, including diathermy, ultrasonic, whirlpool, or heat treatments, adjustments, manipulation, massage or any form of physical therapy.
13. X-ray expenses (including reading charges) but not for dental X-rays unless to evaluate a **Covered Injury**.
14. Radiological procedures.
15. Diagnostic imaging expenses including Magnetic Resonance Imaging (MRI) and Computed Axial Tomography (CAT) Scan.
16. Ambulance expenses for transportation from the emergency site to the **Hospital** [(excluding air ambulance)].
17. Rehabilitative braces or appliances prescribed by a **Physician**. It must be durable medical equipment that:
 - a. is primarily and customarily used to serve a medical purpose;
 - b. can withstand repeated use; and
 - c. generally is not useful to a person in the absence of injury.
 No benefits will be paid for rental charges in excess of the purchase price.
18. Prescription drug expenses for **Covered Injuries**, prescribed by a **Physician** and administered on an outpatient basis.
19. Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for [an **Insured**] [a **Covered Person**]. **We** will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs, eyeglasses and hearing aids.
20. Expenses for blood and blood transfusions; oxygen; and its administration.

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

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

Hospital means an institution which:

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

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

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

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

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

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

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

Medically Necessary means that the medical service or treatment:

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

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

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

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

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

EXCLUSIONS:

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

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

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

EXCESS CORRIDOR

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

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

We will pay the **Usual and Customary** amount, reduced by any other insurance plan and the deductible amount, up to the maximum specified on the this rider. In no event will **We** pay more than the maximum amount stated in this rider.

[If there is no primary **In Force Policy**, a [\$500.00] deductible will apply.]

[SUBROGATION]

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

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

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

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

Catastrophe Cash Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

1. satisfies the **Benefit Waiting Period**; and
2. must be determined by a **Physician** to be permanent and irreversible at the end of that **Benefit Waiting Period**; and
3. must result in **Disability**.

The benefit is payable based on the following table:

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

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

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

The benefit payable is:

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

[MONTHLY: The amounts at the end of the **Benefit Waiting Period**. The benefit is payable monthly as long as [an **Insured**] [a **Covered Person**] remains continuously **Disabled** due to the **Paralysis, Coma, or Brain Death** but ceases on the earlie[r/st] of:

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

[LUMP SUM THEN MONTHLY: The Initial Lump Sum amount payable at the end of the **Benefit Waiting Period**; followed by a monthly Catastrophe Cash benefit equal to [the percentage amount for the number of months] [prorated by the number of months][amounts] stated in the Schedule, starting one month after the end of the **Benefit Waiting Period**. The monthly Catastrophe Cash benefit is payable monthly as long as the [**Insured**] [**Covered Person**] remains continuously **Disabled** due to the **Paralysis, Coma, or Brain Death** but ceases on the earlie[r/st] of:

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

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

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

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

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

Benefit Waiting Period means the [three (3)] consecutive months at the start of a period of continuous **Disability** for which **We** will not pay benefits.

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

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

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

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

Limb means an entire arm or entire leg.

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

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

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

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

Coma Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If [an **Insured**] [a **Covered Person**] suffers a **Covered Injury** resulting in a **Covered Loss** within [365] days of a **Covered Accident**, and such **Covered Injury** causes the [Insured] [Covered Person] to be in a **Coma** for at least [thirty-one (31)] consecutive days, **We** will pay a Coma Benefit.

The Coma Benefit is equal to the amount shown on the Schedule and will be paid each month the [Insured] [Covered Person] remains in a **Coma** following the initial [thirty-one (31)] day period. [The Coma Benefit will be payable per the Schedule per month for the first [eleven (11)] months the [Insured] [Covered Person] remains in a **Coma**, following the initial [thirty-one (31)] day period. At the end of the [eleven (11)] months of payment, if the [Insured] [Covered Person] remains in a **Coma**, **We** will pay a lump sum benefit equal to the **Principal Sum** payable under the Accidental Death Benefit less the amount of the [eleven (11)] months of benefit already received.]

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

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

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

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

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

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

Emergency Treatment Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

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

Emergency Treatment means treatment for:

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

[Hospital] means an institution which:

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

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

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

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

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

Medically Necessary means an Emergency Treatment that:

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

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

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

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

Funeral Expense Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

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

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

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

In-Hospital Indemnity Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

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

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

Hospital means an institution which:

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

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

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

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

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

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

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

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

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

Policyholder Sponsored Activity Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

If the [**Insured**] [**Covered Person**] suffers a **Covered Injury** arising out of a **Policyholder Sponsored Activity** that results in a **Covered Loss**, whom [at the direction of a **Physician**] is prevented from continuing to participate in that **Policyholder Sponsored Activity**, **We** will pay an additional benefit equal to the amount shown on the Schedule.

For purposes of this rider only, **Policyholder Sponsored Activity** means that activity in which the **Insured** paid money to attend and is organized, administered, endorsed, or arranged by the **Policyholder**.

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

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

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

Terrorism Benefit



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

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

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

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

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

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

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

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

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

Travel Assistance Coverage



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

This Travel Assistance Coverage will apply to the following **Covered Persons** when they are traveling [100] mile(s) or more from their **Principal Residence**:

[If the **Insured** pays the premium: [the **Insured** and his or her **Spouse** [/Domestic Partner] and/or **Dependent Child(ren)**, if covered under this **Policy**.]

[If the **Policyholder** pays the premium: [the **Insured** and his or her **Spouse** [/Domestic Partner] and/or **Dependent Child(ren)** if the **Spouse** [/Domestic Partner] and/or **Dependent Child(ren)** are with the **Insured** while he or she is covered under this **Policy**.] [The **Spouse** [/Domestic Partner] or **Dependent Child(ren)** will not be covered while making a trip without the **Insured**.]

The transportation and/or services provided under this Travel Assistance Coverage must be pre-authorized by **Us**. Under this rider the Travel Assistance Coverage consists of the following:

MEDICAL EVACUATION

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

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

MEDICAL REPATRIATION

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

NON-MEDICAL REPATRIATION

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the

attending **Physician**. The upgrade will be subject to **Our** sole discretion. [The maximum amount **We** will pay for Non-Medical Repatriation is shown on the Schedule].

RETURN OF REMAINS

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

VISIT TO HOSPITAL

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

RETURN OF CHILD

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

RETURN OF COMPANION

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

TRAVEL ASSISTANCE COVERAGE EXCLUSIONS

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

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

8. [the **Illness** resulted in whole or in part from the **Covered Person** being intoxicated. A **Covered Person** will be conclusively presumed to be intoxicated if on or about the time of the incident which required medical treatment the level of alcohol in his or her blood exceeds the amount at which a person is presumed to be intoxicated if operating a motor vehicle in that jurisdiction. A report from a law enforcement officer, medical provider or similar report will be considered proof of the **Covered Person's** intoxication.]

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

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

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

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

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

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

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

TRAVEL ASSISTANCE COVERAGE – OTHER PROVISIONS

Right of Recovery

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

[Excess Coverage

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

Reservation of Rights

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

[Exempted Countries

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

Scope

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

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

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

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

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

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

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



Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

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

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

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

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

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

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

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

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

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

4. [Hemiplegia (total paralysis of upper and lower **Limbs** on one side of the body) [50% of **Principal Sum**]]
5. [Uniplegia (total paralysis of one **Limb**) [25% of **Principal Sum**]]

For purposes of this rider only:

Covered Loss means:

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

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

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

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

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

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

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

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

SERFF Tracking Number: ZURC-127070621 State: Arkansas
 Filing Company: Zurich American Insurance Company State Tracking Number: 48289
 Company Tracking Number: CW AH 32050
 TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment
 Dismemberment
 Product Name: Group Accident Policy - New Optional Riders
 Project Name/Number: /CWAH 32050

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/22/2011
Comments:		
Attachment: ZAIC Group Accident Form Filing Certificate of Readability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	03/22/2011
Comments: Application U-GMC-101-A AR (08/09) was approved on 12/01/2009, State Tr Num: 44163.		

	Item Status:	Status Date:
Satisfied - Item: Explanatory	Approved-Closed	03/22/2011
Comments:		
Attachment: U-GMC 1.2a - Explanatory Memorandum - A.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variables	Approved-Closed	03/22/2011
Comments:		
Attachment: U-GMC-1002a-A CW - Statement of Variables.pdf		

Certificate of Readability



Zurich American Insurance Company

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

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

Form Number	Title	Flesch Score
U-GMC-100-A (08/09)	Group Accident Insurance Policy	54
U-GMC-101-A (08/09)	Application	61
U-GMC-102-A (08/09)	Group Accident Insurance Certificate	58
U-GMC-104-A (08/09)	Blank Endorsement	43
U-GMC-110-A (08/09)	[Higher] Education Benefit	47
U-GMC-111-A (08/09)	Common Carrier Benefit	44
U-GMC-112-A (08/09)	Common Disaster Benefit	48
U-GMC-113-A (08/09)	Carjacking Benefit	41
U-GMC-114-A (08/09)	Felonious Assault Benefit	45
U-GMC-115-A (08/09)	Rehabilitation Benefit	43
U-GMC-116-A (08/09)	Seat Belt [Air Bag] Benefit	38
U-GMC-118-A (08/09)	Identity Theft Resolution Services Benefit	37

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

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

Signature: 

Officer: Lisa Plante

Title: Vice President, Accident & Health

Date: September 1, 2009



Zurich American Insurance Company

**EXPLANATORY MEMORANDUM
Group Accident Insurance Policy Riders
For use with U-GMC-100-A (08/09), et al
Company Filing Number – CW AH 32050**

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

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

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

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

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

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

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

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

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

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

Statement of Variables



Zurich American Insurance Company
 1400 American Lane
 Schaumburg, Illinois 60196

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

ACCIDENT WEEKLY INDEMNITY BENEFIT - U-GMC-117-A CW (01/11)

<p>Accident Weekly Indemnity Benefit</p> <p>We will pay an Accident Weekly Indemnity Benefit provided:</p> <p>1. the Total Disability occurs within [thirty (30)] days of the date of the Covered Injury;</p> <p>Payments will begin on the first day after the Benefit Waiting Period and will continue for as long as the [Insured][Covered Person] is Totally Disabled, but will not exceed the Benefit Period of [fifty-two (52)] weeks. The amount of the payments will be equal to the amount shown on the Schedule</p> <p>[reduced by [(1) Workers' Compensation Disability Benefit]; [(2) Social Security Disability Benefits excluding any amounts for which the Insured's Dependents may qualify because of the Insured's disability]; [(3) Social Security Retirement Benefits]; [(4) Group Disability Benefits]; [(5) the amount of any disability income benefits from any automobile or no-fault policy or insurance].</p> <p>Benefit Waiting Period means the [thirty (30)] consecutive days at the start of a period of continuous Total Disability for which We will not pay benefits.</p> <p>Total Disability (Totally Disabled) means disability that:...[or if for [an Insured][a Covered Person] who is not employed means that the person is unable to engage any of the usual activities of a person of like age and sex whose health is comparable to that of the Insured][Covered Person] immediately prior to the Accident]...</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>The range will be 30 – 365.</p> <p>The range will be 4 – 260. The amount shown on the Schedule will have a range from \$50 to \$10,000.</p> <p>This will be in or out. If in: Any combination of 1;2;3;4;5 may be in or out and the numbers will be adjusted accordingly.</p> <p>The range will be 0 – 365.</p> <p>This will be in or out.</p> <p>[not] will be in or out.</p>
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ACCIDENTAL DISMEMBERMENT [AND COVERED LOSS OF USE] [AND PLEGIA] COVERAGE FOR DEPENDENT CHILDREN - U-GMC-119-A CW (01/11)

<p>Accidental Dismemberment [and Covered Loss of Use] [and Plegia] for Dependent Children]</p> <p>[365 days]</p> <p>Percentage of the Insured's Principal Sum</p> <ol style="list-style-type: none"> [50%] to a maximum of \$[100,000] [25%] to a maximum of \$[50,000] [25%] to a maximum of \$[50,000] [12.5%] to a maximum of \$[25,000] [12.5%] to a maximum of \$[25,000] <p>[A reduced benefit will be payable equal to [50%] of the applicable Accidental Dismemberment Benefit after [365 days],</p> <p>[Covered Loss of Use of</p> <ol style="list-style-type: none"> Four Limbs [50%] to a maximum of \$[100,000] Three Limbs [37.5%] to a maximum of \$[75,000] Two Limbs [33%] to a maximum of \$[66,000] One Limb [25%] to a maximum of \$[50,000] <p>[Plegia</p> <ol style="list-style-type: none"> Quadriplegia [50%] to a maximum of [100,000] [Triplegia [37.5%] to a maximum of \$[75,000]] Paraplegia [33%] to a maximum of \$[66,000] Hemiplegia [25%] to a maximum of \$[50,000] [Uniplegia (total paralysis of one Limb)] [12.5%] to a maximum of \$[25,000]] <p>[Covered Loss includes [Covered Loss of Use] [and] [Plegia].]</p> <p>[Covered Loss of Use means total paralysis of a Limb or Limbs, which [has continued for [twelve 12] consecutive months and] is determined by Our competent medical authority to be permanent, complete and irreversible. Limb shall mean an arm or a leg.]</p> <p>[Plegia must [continue for [twelve 12] consecutive months and] be determined by Our competent medical authority to be total, permanent, complete and</p>	<p>This will be either in or out. If in,</p> <p>The range will be 180-365 days</p> <p>The ranges will be:</p> <ol style="list-style-type: none"> 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 25%-75% \$25,000-\$500,000 10%-50% \$10,000-\$250,000 10%-50% \$10,000-\$250,000 5%-25% \$ 5,000-\$125,000 This will be either in or out, If in, the range will be: 5%-25% \$ 5,000-\$125,000 <p>This will be either in or out. If in, The range will be 25%-75%. The range will be 90-365 days.</p> <p>This will be either in or out. If in: The ranges will be: 25%-75% \$25,000-\$500,000 30%-80% \$15,000-\$300,000 15%-60% \$15,000-\$300,000 10%-50% \$10,000-\$200,000</p> <p>This will be either in or out. If in, The ranges will be: 1. 25%-75% \$25,000-\$500,000 2. This will be either in or out. If in, the range will be: 20%-50% \$20,000-\$400,000 3. 15%-60% \$15,000-\$300,000 4. 15%-60% \$15,000-\$300,000 5. This will be in or out. If in, the range will be 10-50% \$10,000-\$200,000</p> <p>This will be in or out. If in: [Covered Loss of Use] will be in or out; [and] will be in or out; and [Plegia] will be in or out.</p> <p>This will be either in or out. If in, The range will be six (6) to eighteen (18) months.</p> <p>This will be either in or out. If in, The range will be six (6) to eighteen (18) months.</p>
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irreversible paralysis of [two] or more **Limb[s]**. A **Limb** means an arm or a leg. Proof of total paralysis may be required by **Us** on a periodic basis. Benefits are not payable for paralysis caused by a stroke.]
[Limb means an arm or a leg.]

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

The range will be one (1) to four (4) limbs.

This will be in or out.

[not] will be in or out.

[OUT OF COUNTRY] ACCIDENT EXCESS CORRIDOR MEDICAL EXPENSE BENEFIT - U-GMC-122-A CW (01/11)

Accident Medical Expense – Excess Corridor Benefit	Maximum Benefit	Deductible	This will be in or out. If in:
[Accident Medical]	[\$10,000]	[\$100]	These will be in or out. The ranges will be as follows:
[Benefit Limitations:]	[\$10,000]	[\$100]	[\$250 to \$2,000,000] [\$0 to \$5,000]
[Accident Dental]	[\$1,000]	[\$100]	[\$100 to \$10,000] [\$0 to \$5,000]
[Pregnancy]	[\$1,000]	[\$100]	[\$100 to \$10,000] [\$0 to \$5,000]
[Custodial Services]	[\$1,000]	[\$100]	[\$100 to \$10,000] [\$0 to \$5,000]
<p>We will pay the [Usual and Customary] expenses for... provided that:</p> <p>1. the first treatment or service occurs within [ninety (90)] days of the Covered Injury ; and</p> <p>2. the medical expenses are incurred within [fifty-two (52)] weeks of the Covered Injury;</p> <p>For the purposes of this rider only, the following definitions apply:</p>			<p>[Usual and Customary] This will be in or out.</p> <p>The range will be 30 – 1,825 days.</p> <p>The range will be 4 - 520 weeks.</p>
<p>Covered Medical Service(s) means...:</p> <p>3. Medical emergency care (room and supplies) expenses incurred within [twenty-four (24)] hours...</p>			<p>The range will be twenty-four (24) to seventy-two (72).</p>
<p>12. Physiotherapy expenses on an inpatient or outpatient basis limited to [one (1)] visit per day to a maximum of [twelve [12] visits.</p>			<p>The range will be one (1) to three (3). The range will be six (6) to eighteen (18).</p>
<p>16. Ambulance expenses for transportation from the emergency site to the Hospital [(excluding air ambulance)].</p>			<p>[(excluding air ambulance)] This will be in or out.</p>
<p>Hospital Confined means admission to a Hospital as an inpatient [for at least 24 consecutive hours] by a Physician for a Covered Injury. A Hospital stay that does not result in charges to the [Insured] [Covered Person] is not a hospital confinement under this rider unless there is no charge because the Hospital is a United States government facility.</p>			<p>This will be in or out.</p>
<p>[Medical Repatriation means...]</p>			<p>This will be in or out.</p>
<p>Pre-existing Condition means a condition for which [an Insured] [Covered Person] received any diagnosis, medical advice or treatment or had taken any prescription medicines during the [six (6)] months immediately preceding the Covered Loss.</p>			<p>The range will be 1 – 24.</p>
<p>[Usual and Customary Expense(s) means...:]</p>			<p>This will be in or out. If in:</p>
<p>[and (3) does not exceed the cost of a generic drug, if available. We will only pay up to [seventy-five percent (75%)] of a non-generic drug if a generic drug is available.]</p>			<p>This will be in or out. If in: The range will be 25% to 100%.</p>

<p>EXCLUSIONS:</p> <p>5. [Travel [into or within] [outside of] the United States of America.]</p> <p>11. Routine physical examinations and related medical services [,][or] [elective treatment or surgery] [,][or] [experimental or investigative treatments or procedures].</p> <p>EXCESS CORRIDOR</p> <p>[If there is no primary In Force Policy, a [\$500.00] deductible will apply.]</p> <p>[SUBROGATION...]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>The following Exclusions will be in or out: 1.;5.;8.;10.; 12.;13.;15.;16.;17.;18.;19.;20.</p> <p>In addition, the following will apply:</p> <p>5. If, in, this will be in or out.</p> <p>11. These will be in or out.</p> <p>This will be in or out. If in, the range will be \$0 to \$5,000.</p> <p>SUBROGATION. This will be in or out.</p> <p>[not] will be in or out.</p>
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CATASTROPHE CASH BENEFIT - U-GMC-125-A CW (01/11)

Catastrophe Cash Benefit

The Policy Schedule will be amended to include the following:

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

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

The benefit is payable based on the following table:

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

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

The benefit payable is:

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

[MONTHLY: The amounts at the end of the **Benefit Waiting Period**. The benefit is payable monthly as long as [an **Insured**][a **Covered Person**] remains continuously **Disabled** due to the **Paralysis, Coma, or Brain Death** but ceases on the earlie[r/st] of:

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

[LUMP SUM THEN MONTHLY: The Initial Lump Sum amount payable at the end of the Benefit Waiting Period as shown on the Schedule; followed by a monthly benefit equal to [the percentage amount for the number of

This will be in or out. If in:

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

The range will be 30 - 365

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

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

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

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

This will be in or out.

This will be in or out. If in

This will be in or out.

This will be in or out. If in:

<p>months][pro-rated by the number of months][amounts] stated in the Schedule, starting one month after the end of the Benefit Waiting Period. The monthly benefit is payable...:</p> <ol style="list-style-type: none"> 1. the date the [Insured] [Covered Person] dies; [or] 2. the date the [Insured] [Covered Person] is no longer Disabled due to the Paralysis or Coma; [or] 3. the date monthly Catastrophe Cash benefits have been paid for the Maximum Number of Months shown in the Schedule for all Disabilities caused by the same Accident.] <p>[If the [Insured] [Covered Person] returns to...Disability.]</p> <p>Benefit Waiting Period means the [three (3)] consecutive months at the start of a period of continuous Disability for which We will not pay benefits.</p> <p>Brain Death means irreversible unconsciousness with total loss of brain function and complete absence of electrical activity of the brain for [six (6)] consecutive months, inclusive of the Benefit Waiting Period, even though the heart is still beating.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out.</p> <p>This will be in or out.</p> <p>The range will be 3 – 24 consecutive months.</p> <p>The range will be 1 – 12 consecutive months.</p> <p>[not] will be in or out.</p>
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COMA BENEFIT - U-GMC-127-A CW (01/11)

<p>Coma Benefit</p> <p>If [an Insured][a Covered Person] suffers a Covered Injury resulting in a Covered Loss within [365] days of a Covered Accident, and such Covered Injury causes the [Insured] [Covered Person] to be in a Coma for at least [thirty-one (31)] consecutive days, We will pay a Coma Benefit.</p> <p>The Coma Benefit is equal to the amount shown on the Schedule and will be paid each month the [Insured] [Covered Person] remains in a Coma following the initial [thirty-one (31)] day period.</p> <p>[The Coma Benefit will be payable per the Schedule per month for the first [eleven (11)] months the [Insured] [Covered Person] remains in a Coma, following the initial [thirty-one (31)] day period. At the end of the [eleven (11)] months of payment, if the [Insured][Covered Person] remains in a Coma, We will pay a lump sum benefit equal to the Principal Sum payable under the Accidental Death Benefit less the amount of the [eleven (11)] months of benefit already received.]</p> <p>The Coma Benefit will end...</p> <p>1. the [Insured][Covered Person] has received the full Coma Benefit for [100] months.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>[365] The range will be 90 to 730 days.</p> <p>[thirty-one (31)] The range will be 31 to 90.</p> <p>The total Coma Benefit amount will not exceed one times the Principal Sum payable per the Schedule. The range will be 1% - 100% of the Principal Sum. [thirty-one (31)] The range will be 31 - 90.</p> <p>This will be in or out. If in:</p> <p>[eleven (11)] The range will be 11 - 24.</p> <p>[thirty-one (31)] The range will be 31 - 90. [eleven (11)] The range will be 11 - 24.</p> <p>[11] The range will be 11 - 24.</p> <p>[100] The range will be 1 - 100.</p> <p>[not] will be in or out.</p>
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EMERGENCY TREATMENT BENEFIT - U-GMC-129-A CW (01/11)

<p>Emergency Treatment Benefit</p> <p>If an [Insured] [Covered Person] suffers a Covered Injury that results in a Covered Loss and, within [forty-eight (48)] hours of the Covered Accident, is required to receive Medically Necessary Emergency Treatment [in the emergency room of a Hospital], We will pay the amount shown on the Schedule. Only one Emergency Treatment Benefit [, the largest,] is payable for any one Covered Accident per [Insured] [Covered Person]. [The maximum number of Emergency Treatment Benefits payable per calendar year per [Insured] [Covered Person] regardless of the number of Covered Accidents incurred, is shown on the Schedule.]</p> <p>[Hospital] means an institution which:</p> <ol style="list-style-type: none"> 1. operates pursuant to law; 2. primarily and continuously provides medical care and treatment to sick and injured persons on an inpatient basis; 3. operates facilities for medical and surgical diagnosis and treatment by or under the supervision of Physicians; and 4. provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.). <p>Hospital does not mean any institution or part thereof which is used primarily as:</p> <ol style="list-style-type: none"> 1. a nursing home, convalescent home, or skilled nursing facility; 2. a place of rest, custodial care, or for the aged; 3. a clinic; or 4. a place for the treatment of mental illness, alcoholism, or substance abuse. <p>However, a place for the treatment of mental illness, alcoholism, or substance abuse will be regarded as a Hospital if it is:</p> <ol style="list-style-type: none"> 1. part of the institution that meets the above requirements; and 2. listed in the American Hospital Association Guide as a general Hospital.] <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p> 	<p>This will be in or out. If in:</p> <p>[48] The range will be 24 - 120.</p> <p>[in the emergency room of a Hospital] This will be in or out. The standard amount shown on the Schedule will be \$500.00 and the range will be \$100.00 - \$10,000.00. [, the largest,] This will be in or out. [The maximum number... Schedule.] This will be in or out. If in, the range will be one (1) to ten (10).</p> <p>This will be in or out.</p> <p>[not] will be in or out.</p>
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FUNERAL EXPENSE BENEFIT - U-GMC-130-A CW (01/11)

<p>Funeral Expense Benefit</p> <p>If [an Insured] [a Covered Person] sustains a Covered Injury that results in a Covered Loss payable under the [Accidental Death] Coverage, We will pay an additional Funeral Expense Benefit amount equal to the Maximum Amount for this Benefit as shown on the Schedule].</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>[Accidental Death] This is to be replaced with other coverages that include an Accidental Death Coverage. The range will be \$1,000 to \$100,000.</p> <p>[not] will be in or out.</p>
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IN-HOSPITAL INDEMNITY BENEFIT - U-GMC-132-A CW (01/11)

<p>In-Hospital Indemnity Benefit</p> <p>If [an Insured][a Covered Person] suffers a Covered Injury resulting in a Covered Loss that requires Hospital Confinement for more than [seven (7)] consecutive days, We will pay the amount shown in the Schedule for a maximum of [twelve (12)] months for any Covered Injury. To be eligible for this benefit, the initial Hospital Confinement period must begin within [ninety (90)] days of the Covered Injury.</p> <p>Successive periods of Hospital Confinement arising out of the same Covered Injury will be considered one confinement only if they are separated by a period of less than [three (3)] months.</p> <p>Hospital Confinement means admission to a Hospital as an inpatient for at least [twenty-four (24)] consecutive hours</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>[seven (7)] The range will be 1 - 30. The amount We will pay on the Schedule will have a range of \$100 to \$1,000 but the total payment amount will not exceed the Principal Sum.</p> <p>[twelve (12)] The range will be 12 - 24. [ninety (90)] The range will be 1 - 365.</p> <p>The range will be 1 - 5</p> <p>The range will be 24 - 48.</p> <p>[not] will be in or out.</p>
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POLICYHOLDER SPONSORED ACTIVITY BENEFIT - U-GMC-135-A CW (01/11)

<p>Policyholder Sponsored Activity Benefit</p> <p>If the [Insured] [Covered Person] suffers a Covered Injury arising out of a Policyholder Sponsored Activity that results in a Covered Loss, whom [at the direction of a Physician] is prevented from continuing to participate in that Policyholder Sponsored Activity, We will pay an additional benefit equal to the amount shown on the Schedule.</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>This will be in or out.</p> <p>The standard benefit amount will be \$3,000.00 and the range will be \$100 to \$50,000.</p> <p>[not] will be in or out</p>
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TERRORISM BENEFIT - U-GMC-136-A CW (01/11)

<p>Terrorism Benefit</p> <p>If [an Insured][a Covered Person] suffers a Covered Injury resulting in a Covered Loss, which is payable under the [Accidental Death] Coverage, that was directly caused by an Act of Terrorism [within the United States] [outside of the United States], We will pay an additional benefit equal to the amount shown on the Schedule.</p> <p>We may cancel this Terrorism Benefit by sending the Policyholder at their most recent address in Our records, a [ten (10)] day notice of Our intent to cancel.</p> <p>[United States means the United States of America [including] [excluding] its territories, possessions, and protectorates.]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy.</p>	<p>This will be in or out. If in:</p> <p>[Accidental Death] This is to be replaced with other coverages that include an Accidental Death Coverage. This will be in or out.</p> <p>This will be in or out.</p> <p>If both [within...] and [outside...] are out, the coverage is worldwide.</p> <p>The amount We will pay will have the following ranges: \$1,000 to \$100,000 or 10% to 100% of the Principal Sum.</p> <p>[ten (10)] The range will be 10 - 180 days.</p> <p>This will be in or out. If in, [including] [excluding] will be in or out.</p> <p>[not] will be in or out.</p>
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TRAVEL ASSISTANCE COVERAGE - U-GMC-137-A CW (01/11)

<p>Travel Assistance Coverage</p> <p>This Travel Assistance Coverage will apply to the following Covered Persons when they are traveling [100] mile(s) or more from their Principal Residence:</p> <p>[If the Insured pays the premium: the Insured and his or her Spouse [/Domestic Partner] and/or Dependent Child(ren), if covered under this Policy.]</p> <p>[If the Policyholder pays the premium: the Insured and his or her Spouse [/Domestic Partner] and or Dependent Child(ren) if the Spouse [/Domestic Partner] and/or Dependent Child(ren) are with the Insured while he or she is covered under this Policy. [The Spouse [/Domestic Partner] or Dependent Child(ren) will not be covered while making a trip without the Insured.]]</p> <p>MEDICAL EVACUATION [in accordance with Western Medical Standards] [The maximum amount We will pay for Medical Evacuation is equal to the amount shown on the Schedule.]</p> <p>MEDICAL REPATRIATION [The maximum amount We will pay for Medical Repatriation is shown on the Schedule].</p> <p>NON-MEDICAL REPATRIATION [The maximum amount We will pay for Non-Medical Repatriation is shown on the Schedule].</p> <p>RETURN OF REMAINS [The maximum amount We will pay for Return of Remains is shown on the Schedule].</p> <p>VISIT TO HOSPITAL If a Covered Person is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a Covered Trip, We... [The maximum amount We will pay for Visit to Hospital is shown on the Schedule].</p> <p>RETURN OF CHILD If a Covered Person is traveling with [a] Dependent Child(ren), who [is][are] under [nineteen (19)] years of age or [a] Child(ren) who prior to age [nineteen (19)] became...</p> <p>[The maximum amount We will pay for Return of Child is shown on the Schedule.]</p> <p>RETURN OF COMPANION [The maximum amount We will pay for Return of Companion is shown on the Schedule].</p>	<p>This will be in or out. If in:</p> <p>[100] The range will be 0 – 1,000.</p> <p>This will be in or out. If in: [/Domestic Partner] will be in or out.</p> <p>This will be in or out. If in: [/Domestic Partner] will be in or out.</p> <p>This will be in or out.</p> <p>This will be in or out. This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p> <p>This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p> <p>This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p> <p>This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p> <p>[seven (7)] The range will be 2 - 30. This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p> <p>[nineteen (19)] The range will be 18 - 30. [nineteen (19)] The range will be 18 - 30.</p> <p>This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p> <p>This will be in or out. If in, the range will be \$5,000 to \$1,000,000.</p>
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TRAVEL ASSISTANCE COVERAGE EXCLUSIONS

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

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

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

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

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

This will be in or out.

TRAVEL ASSISTANCE COVERAGE – OTHER PROVISIONS

[Excess Coverage

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

This will be in or out.

Reservation of Rights

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

This will be in or out.

[Exempted Countries

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

This will be in or out. If in:

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

Scope

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

This will be in or out.

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

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

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

[not] will be in or out.

ACCIDENTAL DISMEMBERMENT [AND LOSS OF] [AND PLEGIA] COVERAGE - U-GMC-146-A CW (01/11)

<p>[Accidental Dismemberment [and Loss of Use] [and Plegia] Coverage [For a Covered Spouse [/Domestic Partner]] [365 days]</p> <ol style="list-style-type: none"> 1. [% of Principal Sum] 2. [% of Principal Sum] 3. [% of Principal Sum] 4. [% of Principal Sum] 5. [% of Principal Sum] 6. [50% of Principal Sum] 7. [50% of Principal Sum] 8. [25% of Principal Sum] 9. [25% of Principal Sum] <p>[A reduced benefit will be payable equal to [50%] of the applicable Accidental Dismemberment Benefit after [365 days],</p> <p>[Covered Loss of Use of</p> <ol style="list-style-type: none"> 1. Four Limbs [100% of Principal Sum] 2. Three Limbs [75% of Principal Sum] 3. Two Limbs [66 2/3% of Principal Sum] 4. One Limb [50% of Principal Sum] <p>[Plegia</p> <ol style="list-style-type: none"> 1. [100% of Principal Sum] 2. [[75% of Principal Sum]] 3. [[66 2/3% of Principal Sum]] 4. [[50% of Principal Sum]] 5. [[Uniplegia][25% of Principal Sum]] <p>[Covered Loss includes [Covered Loss of Use] [and] [Plegia].]</p> <p>[Covered Loss of Use means total paralysis of a Limb or Limbs, which [has continued for [twelve (12)] consecutive months and] is determined by Our competent medical authority to be permanent, complete and irreversible. Limb shall mean an arm or a leg.]</p> <p>[Plegia must [continue for [twelve (12)] consecutive months and] be determined by Our competent medical authority to be total, permanent, complete and irreversible paralysis of [two] or more limb[s].]</p> <p>[Limb means an arm or a leg.]</p> <p>This rider is [not] subject to the limitations in Section V General Limitations of the Policy</p>	<p>This will be either in or out.</p> <p>This will be either in or out. The range will be 180-365 days</p> <ol style="list-style-type: none"> 1. The range will be 50%-200% 2. The range will be 50%-200% 3. The range will be 50%-200% 4. The range will be 50%-200% 5. The range will be 50%-200% 6. The range will be 25%-100% 7. The range will be 25%-100% 8. The range will be 12.5%-50% 9. This will be either in or out. If in, the range will be 25%-50% <p>This will be either in or out. If in, The range will be 25%-75% The range will be 90-365 days</p> <p>This will be either in or out. If in, The range will be 50%-200% The range will be 37.5%-150% The range will be 33 1/3%–125% The range will be 25%-100%</p> <p>This will be either in or out. If in, 1. The range will be 50%-200%. This will be either in or out. If in: 2. The range will be 37.5%-150%. 3. The range will be 33 1/3%-75%. 4. The range will be 25%-100% 5. The range will be 12.5%-100%</p> <p>This will be in or out. If in: [Covered Loss of Use] will be in or out; [and] will be in or out; and [Plegia] will be in or out.</p> <p>This will be either in or out. This will be either in or out. If in, The range will be 6 - 18.</p> <p>This will be either in or out. If in, The range will be 6 - 18.</p> <p>The range will be 1 - 4 limbs.</p> <p>This will be either in or out.</p> <p>[not] will be in or out.</p>
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