

SERFF Tracking Number: MCHX-G127141061 State: Arkansas
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 48595
 Company Tracking Number: AH-20001
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: AH-20001 Blanket Accident - Starr Indemnity & Liab
 Project Name/Number: AH-20001 Blanket Accident - Starr Indemnity & Liability Company /AH-20001 Blanket Accident - Starr Indemnity & Liability Company

Filing at a Glance

Company: Starr Indemnity & Liability Company

Product Name: AH-20001 Blanket Accident - Starr Indemnity & Liab SERFF Tr Num: MCHX-G127141061 State: Arkansas

TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved-Closed State Tr Num: 48595

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: AH-20001 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting Disposition Date: 04/27/2011
 Date Submitted: 04/27/2011 Disposition Status: Approved-Closed

Implementation Date Requested: 05/27/2011

Implementation Date:

State Filing Description:

General Information

Project Name: AH-20001 Blanket Accident - Starr Indemnity & Liability Company Status of Filing in Domicile: Authorized

Project Number: AH-20001 Blanket Accident - Starr Indemnity & Liability Company Date Approved in Domicile: 11/21/2008

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Blanket

Overall Rate Impact:

Filing Status Changed: 04/27/2011

State Status Changed: 04/27/2011

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

Starr Indemnity & Liability Company

NAIC No.: 38318 FEIN: 75-1670124

Blanket Accident Insurance Program

AH -20001 Blanket Accident Insurance Policy

SERFF Tracking Number: MCHX-G127141061 State: Arkansas
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AH-20001 C Certificate of Coverage
AH-20002 Schedule of Benefits
AH-20003 Master Application
AH-20004 Administrative Change Rider
AH-20005-AR Arkansas Rider
Explanation of Variables

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the above-referenced forms on behalf of Starr Indemnity & Liability Company. We have provided a letter of authorization for your files.

We are submitting the above-referenced forms for your review and approval. These forms are new and not intended to replace any other forms currently in use.

This program provides blanket accident only insurance coverage to day cares, schools, day camps, scouting organizations, youth sport groups, and other commonly recognized blanket groups. Coverage is designed to insure the participants and staff against loss due to accidental injuries in reference to the specified hazards as described. The group will select one of three specified hazards - Supervised and Sponsored Activities; Sports Coverage; and, Camp / Conference Coverage. The available benefits are shown on the Schedule of Benefits, form number AH-20002. This program will be marketed through agent/broker solicitation.

Arkansas Rider, form number AH-20005-AR, will be used to bring the Certificate into compliance with Arkansas requirements.

Variable data is bracketed and may vary from case to case. 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 enclosed Explanation of Variables provides more detailed information about the variable text.

Printing of all forms is subject to changes in page numbers, margins, positioning and format. Printing standards will never be less than required under your law. Electronic use of this form may result in changes or variations in margins, formatting and pagination. However, the text will not be less than ten-point type and the form will meet the readability standards required under your law.

Starr Indemnity & Liability 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.

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Attached please find any required certifications and/or transmittal forms and applicable filing fees, if any. If you should have any questions or concerns regarding this submission, please do not hesitate to contact us. We thank you in advance for your time and consideration.

Sincerely,

Jackie Tootchen
 Compliance Projects Team Leader
 McHugh Consulting Resources
 215-230-7960
 mcr@mchughconsulting.com

Company and Contact

Filing Contact Information

Jackie Tootchen, Compliance Project Team Leader mcr@mchughconsulting.com
 McHugh Consulting Resources, Inc. 215-230-7960 [Phone]
 2005 South Easton Road, Suite 207 215-230-7961 [FAX]
 Doylestown, PA 18901

Filing Company Information

(This filing was made by a third party - McHughConsulting)
 Starr Indemnity & Liability Company CoCode: 38318 State of Domicile: Texas
 399 Park Avenue 8th Floor Group Code: Company Type:
 New York , NY 10022 Group Name: State ID Number:
 (646) 227-6528 ext. [Phone] FEIN Number: 75-1670124

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starr Indemnity & Liability Company	\$300.00	04/27/2011	47000866

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/27/2011	04/27/2011

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Disposition

Disposition Date: 04/27/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	Blanket Accident Insurance Policy	Approved-Closed	Yes
Form	Blanket Accident Certificate of Insurance	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form	Administrative Change Rider	Approved-Closed	Yes
Form	Arkansas Rider	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AH-20001

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/27/2011	AH-20001	Policy/Cont	Blanket Accident ract/Fratern Insurance Policy al Certificate	Initial		49.750	AH-20001 3_11.PDF
Approved-Closed 04/27/2011	AH-20001 C	Certificate	Blanket Accident Certificate of Insurance	Initial		45.000	AH-20001C Certificate 3_11.PDF
Approved-Closed 04/27/2011	AH-20002	Schedule	Schedule of Benefits Pages	Initial		63.000	AH-20002 Sched of Benefits 3_11.PDF
Approved-Closed 04/27/2011	AH-20003	Application/Master	Application Enrollment Form	Initial		49.750	AH-20003 - Master App 4 11 - Clean .PDF
Approved-Closed 04/27/2011	AH-20004	Certificate	Administrative Amendmen t, Insert Page, Endorseme nt or Rider	Initial		49.750	AH-20004 - 4 11 Administrative Change Rider .PDF
Approved-Closed 04/27/2011	AH-20005- AR	Policy/Cont	Arkansas Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		46.000	AH-20005-AR Arkansas Rider 3_22_11.PDF



Starr Indemnity & Liability Company

A Member of Starr Companies

Dallas, Texas
Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

Blanket Accident Insurance Policy

Policyholder: [ABC Policyholder]
Policy Number: [12345]
Effective Date: [July 1, 2009 at 12:01 A.M.]

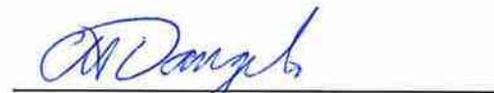
This Policy is a legal contract between the Policyholder and Starr Indemnity & Liability Company (herein referenced as "the Company"). The Company agrees to provide insurance to the Policyholder, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

This Policy is governed by the laws of the state where it was delivered.

Signed for the Company as of the Effective Date above:


[Honora M. Keane], General Counsel


[Charles H. Dangelo], President

**THIS IS A BLANKET ACCIDENT INSURANCE POLICY.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.
PLEASE READ THE POLICY CAREFULLY.**

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DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of this Policy the capitalized terms used herein are defined as follows:

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss or Injury for which benefits are payable.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under this Policy.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy Schedule of Benefits, who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, and for whom the required premium is paid when due.

DEDUCTIBLE means the dollar amount of Covered Expenses that must be incurred by the Covered Person as an out-of-pocket expense for each Accident, before Accident Medical Expense Benefits paid on an expense incurred basis are payable under this Policy. Only one Deductible will apply to the Covered Person and his or her Dependents if Injured in the same Covered Accident.

HOSPITAL means an institution that:

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

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

IMMEDIATE FAMILY means the Covered Person's parent, grandparent, spouse, child(ren) (includes legally adopted children or step children, brother, sister, step-children, grand children, or in-laws.)

INJURY means bodily injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

MEDICAL EMERGENCY means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

MEDICALLY NECESSARY means a treatment, service or supply that is:

- 1) required to treat an Injury;
- 2) prescribed or ordered by a Physician or furnished by a Hospital;
- 3) performed in the least costly setting required by the condition;
- 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting of air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

PHYSICIAN means a person who is a qualified practitioner of the healing arts, including a chiropractor and a dental practitioner. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person or a Covered Person's Immediate Family.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means Starr Indemnity & Liability Company underwriting this insurance.

YOU, YOUR, YOURS, HE or SHE means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the classes of Eligible Persons shown on the Policy Schedule of Benefits, He or She is eligible to be covered under the Policy. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date

A Covered Person's coverage under this Policy begins on the later of:

- 1) the Policy Effective Date;
- 2) the date such person becomes eligible as described in the Schedule of Benefits.

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

This Policy terminates automatically on the earlier of:

- 1) The Policy Termination Date shown in this Policy; or
- 2) The premium due date if premiums are not paid when due subject to any grace period provided.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate this Policy on the last day of the period for which premiums have been paid.

This Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate this Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

A Covered Person's coverage under this Policy ends on the earliest of:

- 1) The date this Policy terminates;
- 2) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
- 3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid; or
- 4) The last day of the period for which premiums have been paid.

PREMIUMS

The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium is due on the Policy Effective Date. After that premium will be due monthly unless otherwise stated in the Policy.

The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

If any premium payment is not paid when due, the Policy will be cancelled as of the premium due date, except as provided under the Grace Period section.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in any federal or state law or regulation affecting this Policy and Our benefit obligation.
- 4) A change in the factors bearing on the risk assumed.
- 5) A misrepresentation in the information relied on in establishing the rate for this Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

[Grace Period

After the payment of the first premium, this Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, this Policy will stay in force provided all the premiums due are paid by the last day of the grace period. This Policy will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid by the last day of the grace period.]

HAZARDS INSURED AGAINST

We will pay benefits described in this Policy when a Covered Person suffers a loss or Injury as a result of a Covered Accident during one of the Covered Activities listed in the Schedule of Benefits. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

[SUPERVISED AND SPONSORED ACTIVITIES

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) attending or participating in a Supervised and Sponsored Activity; or
- (2) attending a Policyholder function, as described on the Schedule of Benefits.

The Covered Person must be:

- (1) on the premises of the Policyholder:
 - (a) during its normal hours;
 - (b) during scheduled functions; and
 - (c) during other periods if He is attending or participating in a Supervised and Sponsored Activity.
- (2) not on the Policyholder's premises and attending or participating in a Supervised and Sponsored Activity;
- (3) traveling directly, without interruption:
 - (a) between the site of the Supervised and Sponsored Activity and the Policyholder's premises, if the Supervised and Sponsored Activity is located within or outside the town where the Policyholder's premises are located.
 - (b) in a vehicle which is:
 - (i) designated or furnished by the Policyholder;
 - (ii) operated by a properly licensed, adult driver; or
 - (iii) under the direct supervision of the Policyholder; or
 - (c) in a vehicle other than that described in (3)(b) when:
 - (i) operated by a properly licensed driver; and
 - (ii) travel time does not exceed one hour each way.

Travel time includes the time:

- (1) to or from the Policyholder's address and the Supervised and Sponsored Activity;
- (2) before the appointed time; and
- (3) after the Supervised and Sponsored Activity is completed.

"Supervised and Sponsored Activity" means a Policyholder authorized function:

- (1) in which the Covered Person participates;
- (2) which is organized by or under its auspices; and
- (3) which is within the scope of customary activities for such entity.]

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.]

[SPORTS COVERAGE

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) taking part in:
 - (a) a regularly scheduled athletic game or competition; or
 - (b) a practice session for an athletic team or club; or
- (2) traveling to or from such a game, competition or practice session provided he is:
 - (a) traveling with the athletic team or club; and
 - (b) under the direct and immediate supervision of:
 - (i) the athletic team or club; or
 - (ii) an adult authorized by the athletic team or club;
 - (c) in a vehicle which is:
 - (i) designated or furnished by the athletic team or club;
 - (ii) operated by a properly licensed, adult driver, or
 - (iii) under the direct supervision of the athletic team or club; or
 - (d) in a vehicle other than that described in (3)(c) when:
 - (i) operated by a properly licensed driver, and
 - (ii) travel time does not exceed one hour each way.

Travel time includes the time:

- (1) to or from a scheduled game, competition or practice session;
- (2) before required attendance time;
- (3) after the Covered Person is dismissed; and
- (4) after the Covered Person completes extra duties assigned by the Policyholder.

Conditions which result over a period of time (including but not limited to blisters, tennis elbow, heat exhaustion, hernia, repetitive stress injury), and which are a normal, foreseeable result of the sport, are not covered. These items are considered a sickness and are not covered.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.]

[CAMP / CONFERENCE COVERAGE]

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is attending or participating in a Camp/Conference. The Covered Person must be:

- (1) on the location of the Camp/Conference:
 - (a) during its normal hours;
 - (b) during scheduled functions; and
 - (c) during other periods if he is attending or participating in a Supervised and Sponsored Activity of the Camp/Conference.
- (2) not on the location of the Camp/Conference and attending or participating in a Supervised and Sponsored Activity of the Camp/Conference;
- (3) traveling directly, without interruption:
 - (a) between the site of the Supervised and Sponsored Activity of the Camp/Conference and the location of the Camp/Conference, if the Supervised and Sponsored Activity is located within or outside the town where the Camp/Conference is located.
 - (b) in a vehicle which is:
 - (i) designated or furnished by the Policyholder;
 - (ii) operated by a properly licensed, adult driver; or
 - (iii) under the direct supervision of the Policyholder; or
 - (c) in a vehicle other than that described in (3)(b) when:
 - (i) operated by a properly licensed driver; and
 - (ii) travel time does not exceed one hour each way.

Travel time includes the time:

- (1) to or from the Camp/Conference location and the Supervised and Sponsored Activity of the Camp/Conference;
- (2) before the appointed time; and
- (3) after the Camp/Conference and/or Supervised and Sponsored Activity of the Camp/Conference is completed.

"Camp/Conference" means a scheduled educational, sports, social or professional program at a facility owned, leased, rented or otherwise contracted for by the Policyholder to conduct such program. A Camp/Conference must:

- (1) have a director or person who is in charge of the program on behalf of the Policyholder; and
- (2) have organized activities; and
- (3) have registered participants.

"Supervised and Sponsored Activity" means a Policyholder authorized function:

- (1) in which the Covered Person participates;
- (2) which is organized by or under its auspices; and
- (3) which is within the scope of customary activities for such entity.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.]

DESCRIPTION OF BENEFITS

All benefits payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Loss Period as shown in the Schedule of Benefits from the date of the Covered Accident that caused the Injury, the Company will pay the percentage of the Principal Sum/Amount of Insurance shown below for that Loss. The Principal Sum/Amount of Insurance is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit, the largest, will be paid for all Losses due to the same Covered Accident.

Loss of:	Benefit:
(Percentage of Principal Sum/Amount of Insurance)	
Life.....	100%
Two or More Members.....	100%
One Member	50%
Thumb and Index Finger of the Same Hand	25%

"Member" means Loss of Hand or Foot and Loss of Sight. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Factors, Co-payments, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

- 1) for Usual and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
- 3) for Covered Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses, from a Covered Accident, include:

- 1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days 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) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
- 4) Registered nurse services expenses for private duty nursing while a Covered Person is Hospital confined, when services are ordered by a Physician.
- 5) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
- 6) Outpatient surgery expenses, including an ambulatory surgical center.
- 7) Outpatient surgical room and supply expenses for use of the surgical facility.
- 8) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
- 9) 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.
- 10) Second surgical opinion expenses.
- 11) Physician surgical expenses. If an 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 and 50% of Covered Expenses for the additional surgeries.
- 12) Assistant surgeon expenses when Medically Necessary.
- 13) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 14) Outpatient laboratory test expenses.
- 15) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
- 16) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
- 17) X-ray expenses (including reading charges) not including dental x-rays.
- 18) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
- 19) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole, sound and a natural tooth at the time of the Covered Accident.
- 20) Outpatient registered nurse services if ordered by a Physician.
- 21) Ambulance expenses for transportation from the Accident site to the Hospital.

- 22) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and 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.
- 23) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
- 24) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
- 25) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
- 26) Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment.
- 27) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.

Terms of Payment for Accident Medical and Dental Expense Benefit

[Full Excess:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable under the Policy are shown on the Schedule of Benefits.

Failure by a Covered Person to follow the terms and conditions of His primary coverage will result in a benefit reduction of Eligible Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

For the purposes of this provision, "Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- (1) group or blanket insurance, whether on an insured or self-funded basis;
- (2) Hospital or medical service organizations on a group basis;
- (3) Health Maintenance Organizations on a group basis;
- (4) group labor management plans;
- (5) employee benefit organization plan;
- (6) professional association plans on a group basis;
- (7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- (8) automobile no-fault coverage (unless prohibited by law).]

[Primary:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits. Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable under the Policy is shown on the Schedule of Benefits.]

EXCLUSIONS

This Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of, any of the following even if the immediate cause of the loss is an accidental bodily injury:

- [Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.]
- [War or any act of war, declared or undeclared.]
- [Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.]
- [Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.]
- [Covered Expenses for which the Covered Person would not be responsible in the absence of this Policy.]
- [Injuries paid under workers' compensation, employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.]
- [Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.]
- [Service or active duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.]
- [Services or treatment rendered by a Physician, nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Covered Person.]
- [Treatment of a hernia, Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.]
- [Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in this Policy.]
- [Eyeglasses, contact lenses, hearing aids.]
- [Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.]

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at Starr Indemnity & Liability Company, [90 Park Avenue, 7th Floor, New York, NY 10016, Attn: Claims Department]. Notice should include the Covered Person's name and address as well as this Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

PROOF OF LOSS: Written proof of loss must be given to the Company within 90 days after the date of loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by this Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by this Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of this Policy entitled 'General Policy Provisions. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10th day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of this Policy entitled 'General Policy Provisions.'

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

- 1) A request for lump sum payment of the amount overpaid or paid in error, or
- 2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

SUBROGATION: The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by this Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under this Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party. The Company agrees to pay its portion of the Policyholder's reasonable attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this Policy pursuant to its subrogation right.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT/CHANGES: This Policy, with the Policyholder's Master Application and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company. Changes to this Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of this Policy to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest this Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the person who made the statement, or to their beneficiary or representative. No such statement will be used to contest this Policy after this Policy has been in force for two years.

CERTIFICATES OF INSURANCE: The Company will issue to the Policyholder certificates of insurance for delivery to each Covered Person covered by this Policy, where required by law. Certificates will list the benefits, conditions and limits of this Policy and to whom benefits will be paid.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy in conflict on its effective date with the laws of the state where the Covered Person lives is amended to conform to the minimum requirements of such laws.

DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

- 1) Beneficiaries designated in writing by the Covered Person for this Policy on file with the Policyholder, if any, otherwise;
- 2) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Covered Person's lawful spouse, if not legally separated or divorced;
 - b) a Covered Person's natural Child, adopted Child, foster Child, step Child, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
 - c) a Covered Person's parents, whether natural, step or adoptive; otherwise;
- 3) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

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

LEGAL ACTION: All Policy terms will be interpreted under the laws of the state in which this Policy was issued. No legal action may be brought to recover on this Policy within 60 days after written Proof of Loss has been furnished, No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Third Party Administrator or other Agent in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would have affected the rates, Deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, Deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

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

WORKERS' COMPENSATION: This Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.



Starr Indemnity & Liability Company

A Member of Starr Companies

Dallas, Texas
Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

Blanket Accident Certificate of Insurance

Policyholder: [ABC Policyholder]
Policy Number: [12345]
Effective Date: [July 1, 2009 at 12:01 A.M.]

This Certificate of Insurance describes the coverage provided under the Policy. The Policy is the legal contract between the Policyholder and Starr Indemnity & Liability Company (herein referenced as "the Company"). The Policy may be examined, upon request, at the office of the Policyholder. This Certificate of Insurance replaces any Certificate of Insurance that may have been previously issued to the Covered Person under the Policy.

The Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Policyholder on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in the Policy.

The Policy is governed by the laws of the state where it was delivered.

Signed for the Company as of the Effective Date above:


[Honora M. Keane], General Counsel


[Charles H. Dangelo], President

**THIS IS BLANKET ACCIDENT INSURANCE.
THE POLICY DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS.
PLEASE READ THIS CERTIFICATE CAREFULLY.**

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DEFINITIONS

The male pronoun includes the female whenever used.

For the purposes of the Policy the capitalized terms used herein are defined as follows:

ACCIDENT means a sudden, unexpected event that results in Injury to the Covered Person.

BENEFIT PERIOD means the period of time, as stated on the Schedule of Benefits, between the date of the Accident causing the Injury for which benefits are payable and the date after which no further benefits will be paid.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss or Injury for which benefits are payable.

COVERED LOSS or COVERED LOSSES means an accidental death, dismemberment or other Injury covered under the Policy.

COVERED PERSON means an eligible person who is within the covered class(es) listed in the Policy Schedule of Benefits, who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States, and for whom the required premium is paid when due.

DEDUCTIBLE means the dollar amount of Covered Expenses that must be incurred by the Covered Person as an out-of-pocket expense for each Accident, before Accident Medical Expense Benefits paid on an expense incurred basis are payable under the Policy. Only one Deductible will apply to the Covered Person and his or her Dependents if Injured in the same Covered Accident.

HOSPITAL means an institution that:

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

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

IMMEDIATE FAMILY means the Covered Person's parent, grandparent, spouse, child(ren) (includes legally adopted children or step children, brother, sister, step-children, grand children, or in-laws.)

INJURY means bodily injury caused by the direct result of an Accident occurring while the Policy is in force as to the person whose injury is the basis of the claim which results, directly and independently of all other causes, in a Covered Loss.

MEDICAL EMERGENCY means a condition caused by an Injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

MEDICALLY NECESSARY means a treatment, service or supply that is:

- 1) required to treat an Injury;
- 2) prescribed or ordered by a Physician or furnished by a Hospital;
- 3) performed in the least costly setting required by the condition;
- 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting of air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

PHYSICIAN means a person who is a qualified practitioner of the healing arts, including a chiropractor and a dental practitioner. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person or a Covered Person's Immediate Family.

USUAL AND CUSTOMARY CHARGES means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means Starr Indemnity & Liability Company underwriting this insurance.

YOU, YOUR, YOURS, HE or SHE means the Covered Person who meets the eligibility requirements of the Policy and whose insurance under the Policy is in force.

ELIGIBILITY FOR INSURANCE

If the Covered Person is in one of the classes of Eligible Persons shown on the Policy Schedule of Benefits, He or She is eligible to be covered under the Policy. We retain the right to investigate eligibility status and attendance records to verify eligibility requirements are met. If We discover the eligibility requirements are not met, Our only obligation is to refund any premium paid for that person.

EFFECTIVE DATE OF INSURANCE

Policy Effective Date. The Policy begins on the Policy Effective Date shown in the Schedule of Benefits at 12:01 A.M. at the address of the Policyholder.

Covered Person's Effective Date

A Covered Person's coverage under the Policy begins on the later of:

- 1) the Policy Effective Date; or
- 2) the date such person becomes eligible as described in the Schedule of Benefits

TERMINATION DATE OF INSURANCE

Policy Termination Date

Termination takes effect at 12:01 A.M. time at the address of the Policyholder on the date of termination. Termination by the Policyholder or by the Company will be without prejudice to any claims originating prior to the date of termination.

The Policy terminates automatically on the earlier of:

- 1) The Policy Termination Date shown in the Policy; or
- 2) The premium due date if premiums are not paid when due subject to any grace period provided.

Failure by the Policyholder to pay all required premiums due by the last day of the grace period shall be deemed notice by the Policyholder to the Company to terminate the Policy on the last day of the period for which premiums have been paid.

The Policy may be terminated by the Policyholder or the Company as of any premium due date or Policy Anniversary Date by giving written notice to the other at least 31 days prior to such date.

The Policyholder and the Company may terminate the Policy at any time by written mutual consent.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

Covered Person's Termination Date

A Covered Person's coverage under the Policy ends on the earliest of:

- 1) The date the Policy terminates;
- 2) The date the Covered Person enters full-time active duty in the armed forces of any country or international authority;
- 3) The date the Covered Person ceases to be eligible as described in the Policy provided all required premiums are paid;
or
- 4) The last day of the period for which premiums have been paid.

PREMIUMS

The Company provides insurance in return for premium payments. The premium showed in the Schedule of Benefits is payable to the Company in the manner described and is based on rates currently in force, the plan, and the amount of insurance in force. Premium is due on the Policy Effective Date. After that premium will be due monthly unless otherwise stated in the Policy.

The Company has the right to rely upon the accuracy of the Policyholder's calculations and to require the Policyholder to furnish a census from time to time but not more than twice in a 12-month period. If, at any time, it is determined that additional premium or a premium credit is due, the Policyholder will pay the additional premium or apply the premium credit at the next premium due date.

If any premium payment is not paid when due, the Policy will be cancelled as of the premium due date, except as provided under the Grace Period section.

Changes in Premium Rate

The Company may change the premium rates from time to time with at least 31 days advanced written or authorized electronic notice. No change in rates will be made until 12 months after the Policy Effective Date. However, the Company reserves the right to change rates at any time if any of the following events occur:

- 1) A change in the terms of the Policy.
- 2) A subsidiary, division, affiliated organization or eligible class is added or deleted to the Policy.
- 3) A change in any federal or state law or regulation affecting the Policy and Our benefit obligation.
- 4) A change in the factors bearing on the risk assumed.
- 5) A misrepresentation in the information relied on in establishing the rate for the Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a prorated adjustment will apply from the date of the change to the next Premium Due Date.

[Grace Period

After the payment of the first premium, the Policy will have a 31 day grace period. This means that if premium is not paid on or before the date it is due, it may be paid during the 31 day grace period. During this time, the Policy will stay in force provided all the premiums due are paid by the last day of the grace period. The Policy will terminate on the last day of the period for which all premiums have been paid if all premiums due are not paid by the last day of the grace period.]

HAZARDS INSURED AGAINST

We will pay benefits described in the Policy when a Covered Person suffers a loss or Injury as a result of a Covered Accident during one of the Covered Activities listed in the Schedule of Benefits. Unless otherwise specified, We pay benefits only once for any one Covered Accident, even if it is covered by more than one Hazard.

[SUPERVISED AND SPONSORED ACTIVITIES

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) attending or participating in a Supervised and Sponsored Activity; or
- (2) attending a Policyholder function, as described on the Schedule of Benefits.

The Covered Person must be:

- (1) on the premises of the Policyholder:
 - (a) during its normal hours;
 - (b) during scheduled functions; and
 - (c) during other periods if He is attending or participating in a Supervised and Sponsored Activity.
- (2) not on the Policyholder's premises and attending or participating in a Supervised and Sponsored Activity;
- (3) traveling directly, without interruption:
 - (a) between the site of the Supervised and Sponsored Activity and the Policyholder's premises, if the Supervised and Sponsored Activity is located within or outside the town where the Policyholder's premises are located.
 - (b) in a vehicle which is:
 - (i) designated or furnished by the Policyholder;
 - (ii) operated by a properly licensed, adult driver; or
 - (iii) under the direct supervision of the Policyholder; or
 - (c) in a vehicle other than that described in (3)(b) when:
 - (i) operated by a properly licensed driver; and
 - (ii) travel time does not exceed one hour each way.

Travel time includes the time:

- (1) to or from the Policyholder's address and the Supervised and Sponsored Activity;
- (2) before the appointed time; and
- (3) after the Supervised and Sponsored Activity is completed.

"Supervised and Sponsored Activity" means a Policyholder authorized function:

- (1) in which the Covered Person participates;
- (2) which is organized by or under its auspices; and
- (3) which is within the scope of customary activities for such entity.]

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.]

[SPORTS COVERAGE

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is:

- (1) taking part in:
 - (a) a regularly scheduled athletic game or competition; or
 - (b) a practice session for an athletic team or club; or
- (2) traveling to or from such a game, competition or practice session provided he is:
 - (a) traveling with the athletic team or club; and
 - (b) under the direct and immediate supervision of:
 - (i) the athletic team or club; or
 - (ii) an adult authorized by the athletic team or club;
 - (c) in a vehicle which is:
 - (i) designated or furnished by the athletic team or club;
 - (ii) operated by a properly licensed, adult driver, or
 - (iii) under the direct supervision of the athletic team or club; or
 - (d) in a vehicle other than that described in (3)(c) when:
 - (i) operated by a properly licensed driver, and
 - (ii) travel time does not exceed one hour each way.

Travel time includes the time:

- (1) to or from a scheduled game, competition or practice session;
- (2) before required attendance time;
- (3) after the Covered Person is dismissed; and
- (4) after the Covered Person completes extra duties assigned by the Policyholder.

Conditions which result over a period of time (including but not limited to blisters, tennis elbow, heat exhaustion, hernia, repetitive stress injury), and which are a normal, foreseeable result of the sport, are not covered. These items are considered a sickness and are not covered.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.]

[CAMP / CONFERENCE COVERAGE]

We will pay the benefits described in the Policy for an Accident which occurs while a Covered Person is attending or participating in a Camp/Conference. The Covered Person must be:

- (1) on the location of the Camp/Conference:
 - (a) during its normal hours;
 - (b) during scheduled functions; and
 - (c) during other periods if he is attending or participating in a Supervised and Sponsored Activity of the Camp/Conference.
- (2) not on the location of the Camp/Conference and attending or participating in a Supervised and Sponsored Activity of the Camp/Conference;
- (3) traveling directly, without interruption:
 - (a) between the site of the Supervised and Sponsored Activity of the Camp/Conference and the location of the Camp/Conference, if the Supervised and Sponsored Activity is located within or outside the town where the Camp/Conference is located.
 - (b) in a vehicle which is:
 - (i) designated or furnished by the Policyholder;
 - (ii) operated by a properly licensed, adult driver; or
 - (iii) under the direct supervision of the Policyholder; or
 - (c) in a vehicle other than that described in (3)(b) when:
 - (i) operated by a properly licensed driver; and
 - (ii) travel time does not exceed one hour each way.

Travel time includes the time:

- (1) to or from the Camp/Conference location and the Supervised and Sponsored Activity of the Camp/Conference;
- (2) before the appointed time; and
- (3) after the Camp/Conference and/or Supervised and Sponsored Activity of the Camp/Conference is completed.

"Camp/Conference" means a scheduled educational, sports, social or professional program at a facility owned, leased, rented or otherwise contracted for by the Policyholder to conduct such program. A Camp/Conference must:

- (1) have a director or person who is in charge of the program on behalf of the Policyholder; and
- (2) have organized activities; and
- (3) have registered participants.

"Supervised and Sponsored Activity" means a Policyholder authorized function:

- (1) in which the Covered Person participates;
- (2) which is organized by or under its auspices; and
- (3) which is within the scope of customary activities for such entity.

Unless otherwise stated in the Schedule of Benefits, We will pay benefits for a Covered Loss, only once, even if coverage was provided under more than one Hazard.]

DESCRIPTION OF BENEFITS

All benefits payable are shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If Injury to the Covered Person results in any of the Covered Losses shown below, within the Loss Period as shown in the Schedule of Benefits from the date of the Covered Accident that caused the Injury, the Company will pay the percentage of the Principal Sum/Amount of Insurance shown below for that Loss. The Principal Sum/Amount of Insurance is shown in the Schedule of Benefits. If multiple losses occur, only one Benefit, the largest, will be paid for all Losses due to the same Covered Accident.

Loss of:	Benefit:
(Percentage of Principal Sum/Amount of Insurance)	
Life.....	100%
Two or More Members.....	100%
One Member	50%
Thumb and Index Finger of the Same Hand	25%

"Member" means Loss of Hand or Foot and Loss of Sight. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total and permanent loss of sight of one/both eyes that is irrecoverable, including by surgical and artificial means. "Loss of thumb and index finger of the same hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

We will pay Accident Medical and Dental Expense Benefits for Covered Expenses that result directly, and from no other cause, from a Covered Accident. These benefits are subject to the Deductibles, Coinsurance Factors, Co-payments, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

Accident Medical Expense Benefits are only payable:

- 1) for Usual and Customary Charges incurred after the Deductible has been met;
- 2) for those Medically Necessary Covered Expenses incurred by or on behalf of the Covered Person;
- 3) for Covered Expenses incurred within 365 days after the date of the Covered Accident.

No benefits will be paid for any expenses incurred that are in excess of Usual and Customary Charges.

Covered Medical Expenses, from a Covered Accident, include:

- 1) Hospital room and board expenses: the daily room rate when a Covered Person is Hospital confined and general nursing care is provided and charged for by the Hospital. In computing the number of days 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) Daily Intensive Care Unit/Cardiac Care Unit Expenses: the daily room rate when a Covered Person is Hospital confined in a bed in the Intensive Care Unit/Cardiac Care Unit and nursing services other than private duty nursing services.
- 4) Registered nurse services expenses for private duty nursing while a Covered Person is Hospital confined, when services are ordered by a Physician.
- 5) Medical Emergency Care (room and supplies) expenses incurred within 72 hours of a Covered Accident and including the attending Physician's charges, x-rays, laboratory procedures, use of the emergency room and supplies.
- 6) Outpatient surgery expenses, including an ambulatory surgical center.
- 7) Outpatient surgical room and supply expenses for use of the surgical facility.
- 8) Outpatient diagnostic x-rays, laboratory procedures and test expenses.
- 9) 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.
- 10) Second surgical opinion expenses.
- 11) Physician surgical expenses. If an 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 and 50% of Covered Expenses for the additional surgeries.
- 12) Assistant surgeon expenses when Medically Necessary.
- 13) Anesthesiologist expenses for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.
- 14) Outpatient laboratory test expenses.
- 15) Physiotherapy (physical medicine) expenses on an inpatient or outpatient basis limited to one visit per day; expenses include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, chiropractic, adjustments, manipulation, massage or any form of physical therapy.
- 16) Post surgical physical medicine expenses and office visits connected with such treatment when prescribed by a Physician.
- 17) X-ray expenses (including reading charges) not including dental x-rays.
- 18) Diagnostic imaging expenses including magnetic resonance imaging (MRI) and CAT scans.
- 19) Dental expenses including dental x-rays for the repair or treatment of each injured tooth that is whole, sound and a natural tooth at the time of the Covered Accident.
- 20) Outpatient registered nurse services if ordered by a Physician.
- 21) Ambulance expenses for transportation from the Accident site to the Hospital.

- 22) Rehabilitative braces or appliances prescribed by a Physician. It must be durable medical equipment that is primarily and customarily used to serve a medical purpose and can withstand repeated use and 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.
- 23) Prescription drug expenses prescribed by a Physician and administered on an outpatient basis.
- 24) Medical equipment rental expenses for a wheelchair or other medical equipment that has therapeutic value for the Covered Person. We will not cover computers, motor vehicles or modifications to a motor vehicle, ramps and installation costs.
- 25) Medical services and supplies for blood and blood transfusions; oxygen and its administration.
- 26) Eyeglasses, contact lenses and hearing aids when damage occurs in a Covered Accident that requires medical treatment.
- 27) Artificial limbs, eyes and larynx for initial acquisition and fitting. We will not pay for repair or replacement of artificial limbs, eyes or larynx.

Terms of Payment for Accident Medical and Dental Expense Benefit

[Full Excess:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable under the Policy are shown on the Schedule of Benefits.

Failure by a Covered Person to follow the terms and conditions of His primary coverage will result in a benefit reduction of Eligible Expense to 50% of the amount otherwise payable under the Policy. This limitation will not apply to emergency treatment required within 24 hours after an Accident when the Accident occurs outside the geographic area served by His primary plan's HMO, PPO or other similar arrangement for provision of benefits or services, if applicable.

For the purposes of this provision, "Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- (1) group or blanket insurance, whether on an insured or self-funded basis;
- (2) Hospital or medical service organizations on a group basis;
- (3) Health Maintenance Organizations on a group basis;
- (4) group labor management plans;
- (5) employee benefit organization plan;
- (6) professional association plans on a group basis;
- (7) any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended; or
- (8) automobile no-fault coverage (unless prohibited by law).]

[Primary:

If a Covered Person incurs Covered Expenses, We will pay the applicable benefit, subject to any applicable Deductible and Benefit Period shown on the Schedule of Benefits. Such benefits will be paid on a primary basis, regardless of any other coverage the Covered Person may have. The first expense must be incurred within the Loss Period stated on the Schedule of Benefits. The Total Benefit Maximum payable under the Policy is shown on the Schedule of Benefits.]

EXCLUSIONS

The Policy does not cover any loss resulting in whole or part from, or contributed to by, or as a natural or probable consequence of, any of the following even if the immediate cause of the loss is an accidental bodily injury:

- [Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.]
- [War or any act of war, declared or undeclared.]
- [Sickness, disease or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.]
- [Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Physician.]
- [Covered Expenses for which the Covered Person would not be responsible in the absence of the Policy.]
- [Injuries paid under workers' compensation, employer's liability laws or similar occupational benefits or while engaging in activity for monetary gain from sources other than the Policyholder.]
- [Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.]
- [Service or active duty in the armed forces, National Guard, military, naval or air service or organized reserve corps of any country or international organization.]
- [Services or treatment rendered by a Physician, nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Covered Person.]
- [Treatment of a hernia, Osgood-Schlatter's disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, whether or not caused by a Covered Accident.]
- [Damage to or loss of dentures or bridges or damage to existing orthodontic equipment, except as specifically provided in the Policy.]
- [Eyeglasses, contact lenses, hearing aids.]
- [Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from: While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.]

CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice of death or Injury must be given to the Company within 30 days after a Covered Loss begins or as soon as reasonably possible. Notice can be given to the Company at Starr Indemnity & Liability Company, [90 Park Avenue, 7th Floor, New York, NY 10016, Attn: Claims Department]. Notice should include the Covered Person's name and address as well as the Policy Number. If written notice is not received within 30 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 30 day period; and
- 2) it is further shown that notice was given as soon as possible.

CLAIM FORMS: When the Company receives a notice of claim, the Company will send forms for filing proof of loss. If claim forms are not sent within 15 days after receipt of such notice, Proof of Loss requirements stated below will be deemed to have been met if, within the Proof of Loss time period specified below, written proof of the nature and extent of the loss is submitted.

PROOF OF LOSS: Written proof of loss must be given to the Company within 90 days after the date of loss. If the proof of loss is not submitted within 90 days, the claim may be reduced or invalidated. However, the claim will not be reduced or invalidated if:

- 1) it can be shown that it was not possible within reason to submit notice within the 90 day period; and
- 2) it is further shown that notice was given as soon as possible, and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Benefits for loss covered by the Policy, other than benefits that require periodic payment, will be paid as soon as the Company receives proper written proof of such loss. Benefits for loss covered by the Policy that require periodic payment shall be paid monthly provided that the Company receives proper written proof of such loss.

PAYMENT OF CLAIMS: All benefits will be paid in United States currency. Loss of life benefits will be paid to the beneficiary as described in the Designation or Change of Beneficiary provision of the Policy entitled 'General Policy Provisions. To receive proceeds, a beneficiary must be living on the earlier of the following dates: the date the Company receives proof of the loss of life; or the 10th day after the death.

All other benefits will be paid to the Covered Person suffering the loss. If the Covered Person dies before all payments due have been made, the amount still payable will be paid to his/her beneficiary as described in the Designation and Change of Beneficiary provision of the Policy entitled 'General Policy Provisions.'

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to have a Physician of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. We will pay the cost of the examination or autopsy.

RECOVERY OF OVERPAYMENT: If benefits are overpaid, or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

- 1) A request for lump sum payment of the amount overpaid or paid in error, or
- 2) Reduction of any proceeds payable under the Policy by the amount overpaid or paid in error.

SUBROGATION: The Policyholder is required to investigate and prosecute all valid claims that it may have against third parties arising out of any claim for which benefits were paid by the Policy. The Policyholder shall account to the Company for all amounts recovered. If the Policyholder fails to pursue any action against a third party and the Company has made benefit payments under the Policy, the Company will be subrogated to all of the Policyholder's rights to make recoveries. However, the Company's subrogation right is secondary to the Policyholder's right to be fully compensated for its damages. The Policyholder is required to cooperate fully and do all things necessary and required for the Company to pursue any action to recover against the third party. The Company agrees to pay its portion of the Policyholder's reasonable attorneys' fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under the Policy pursuant to its subrogation right.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT/CHANGES: The Policy, with the Policyholder's Master Application and all endorsements, amendments and attached papers is the entire contract between the Policyholder and the Company. Changes to the Policy may be made at any time by an endorsement or amendment and must be agreed upon, in writing, between the Policyholder and the Company. The Company may also, upon 31 days written notice to the Policyholder, change or modify the provisions of the Policy to comply with any applicable requirements of the Internal Revenue Service and/or any state or other federal law or regulation. No agent may change the Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, all statements made by the Policyholder or by a Covered Person shall be deemed representations and not warranties. No such statement shall be used to contest the Policy or reduce benefits unless contained in a signed, written application, a copy of which has been provided to the person who made the statement, or to their beneficiary or representative. No such statement will be used to contest the Policy after the Policy has been in force for two years.

CLERICAL ERROR: Clerical error in keeping any records pertaining to the coverage, whether by the Policyholder or by the Company, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated, provided such clerical error is not prejudicial to the Company and is rectified promptly upon discovery.

CONFORMITY WITH STATE STATUTES: Any provision of the Policy in conflict on its effective date with the laws of the state where the Covered Person lives is amended to conform to the minimum requirements of such laws.

DESIGNATION OR CHANGE OF BENEFICIARY: Each Covered Person may designate a beneficiary to whom loss of life benefits are payable. The designation shall be as follows in descending order of preference:

- 1) Beneficiaries designated in writing by the Covered Person for the Policy on file with the Policyholder, if any, otherwise;
- 2) In equal shares to the members of the first surviving class of those that follow, if any:
 - a) a Covered Person's lawful spouse, if not legally separated or divorced;
 - b) a Covered Person's natural Child, adopted Child, foster Child, step Child, or other Child for whom the Covered Person has or had legal guardianship (proof will be required); or
 - c) a Covered Person's parents, whether natural, step or adoptive; otherwise;
- 3) The estate of the Covered Person.

A Covered Person may change his/her beneficiary designation from time to time without the consent of the designated beneficiary by giving notice, in writing, to the Policyholder. When a request for designation or change is received by the Policyholder, it will take effect on the date of its execution, whether or not the Covered Person is living on the date it is received by the Policyholder. Any interest created by the request will be subject to any payment made or action taken before its receipt.

ASSIGNMENT: No assignment of interest in loss of life benefits shall be binding on the Company until the original or duplicate thereof is received by the Company. The Company assumes no responsibility for the validity of such assignment.

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

LEGAL ACTION: All Policy terms will be interpreted under the laws of the state in which the Policy was issued. No legal action may be brought to recover on the Policy within 60 days after written Proof of Loss has been furnished, No legal action may be brought after three (3) years from the time written Proof of Loss is required to be furnished.

MISSTATED DATA: The Company has relied upon the underwriting information provided by the Policyholder, its Third Party Administrator or other Agent in the issuance of the Policy. Should subsequent information become known which, if known prior to issuance of the Policy, would have affected the rates, Deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, Deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Policyholder.

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

WORKERS' COMPENSATION: The Policy is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.



Starr Indemnity & Liability Company

A Member of Starr Companies

Dallas, Texas

Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

SCHEDULE OF BENEFITS

POLICYHOLDER: [ABC Policyholder]

POLICY NUMBER: [12345]

POLICY EFFECTIVE DATE: [July 1, 2009 at 12:01 A.M.]

POLICY PERIOD: [July 1, 2009 at 12:01 A.M. through July 1, 2010 at 12:01 A.M.]

CLASSES OF ELIGIBLE PERSONS:

Enrolled participants of the Policyholder.

HAZARDS INSURED AGAINST:

[Supervised and Sponsored Activities]

[Sports Coverage]

[Camp/Conference Coverage]

Covered Activities:

[List the Supervised and Sponsored Activities to be covered.]

[List the Sports to be covered.]

[List the Camps/Conference to be covered.]

PREMIUMS: [\$123.00]

PREMIUM DUE DATE: [Annual in advance on the Effective Date]

BENEFITS:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Person Principal Sum/Amount of Insurance: [\$1,000 - \$100,000]

Loss Period: [180, 365] days from the date of the Covered Accident

ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT

Total Benefit Maximum for all Accident Medical and Dental:	[\$2,500 - \$500,000]
Loss Period (first Covered Expenses must be incurred within):	[60, 90] days after the Covered Accident
Benefit Period:	[180 days, 1 Year, 2 Years] from the date of the Covered Accident]
Deductible:	[\$0 - \$1,000]
Coinsurance:	[70-100%] of Usual and Customary Charges
Terms of Payment:	[Primary, Full Excess]

Any Deductibles, Coinsurance, Benefit Periods, and Benefit Maximums apply on a per Covered Person, per Covered Accident basis.



Starr Indemnity & Liability Company

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Dallas, Texas

Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

MASTER APPLICATION

Application is made by [ABC Policyholder] (the Policyholder) for Blanket Accident Insurance as shown on the attached Schedule of Benefits.

All statements made by the Policyholder in this application will be deemed representations and not warranties.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

The terms of the Policy are hereby approved and accepted by the named Policyholder. The Policy will take effect on the Effective Date specified on the attached Schedule of Benefits.

Date

Date

Authorized Signature

[Licensed Resident] Agent's Signature

Officer's Name

[Licensed Resident] Agent's Name

Title

[Licensed Resident Agent ID#]



Starr Indemnity & Liability Company

A Member of Starr Companies

Dallas, Texas

Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

ADMINISTRATIVE CHANGE RIDER

This Rider is attached to and made a part of Policy Number [12345] issued to [ABC Company] (the Policyholder).

Effective [12/01/09], the Policy/Certificate are hereby amended as follows:

[To be used for administrative changes only, such as renewing the Policy, changing the number of Covered Persons, updating the premiums, etc.]

Signed for the Company:

[Honora M. Keane], General Counsel

[Charles H. Dangelo], President



Starr Indemnity & Liability Company

A Member of Starr Companies

399 Park Avenue
New York, NY 10022

ARKANSAS RIDER

The Policy/Certificate are hereby amended for Arkansas as follows:

DESCRIPTION OF BENEFITS

The following notice is added to the beginning of the ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT:

BENEFIT PAYMENTS ARE PAYABLE AT THE APPLICABLE COINSURANCE FACTOR AND ARE SUBJECT TO THE DEDUCTIBLE AND MAXIMUM BENEFIT STATED ON THE SCHEDULE OF BENEFITS.

The following benefit is added to the list of Covered Medical Expenses under the ACCIDENT MEDICAL AND DENTAL EXPENSE BENEFIT:

1. Charges for the following outpatient services provided they would be covered if performed on an inpatient basis: laboratory and pathological tests, including machine tests, ordered by the attending Physician when necessary to and rendered in conjunction with the medical or surgical diagnosis or treatment of an Injury.

CLAIMS PROVISIONS

The TIME OF PAYMENT OF CLAIMS provision is replaced with the following:

1. We shall pay or deny a Clean Claim within 30 days after We receive it if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.
2. We shall notify the claimant within 30 days after receipt of the claim if We determine that more information is needed to resolve one or more issues. Our notice shall give an explanation of the additional information that is required. We may suspend the claim until We receive the requested information. We shall reopen and pay or deny a previously suspended claim within 30 days after We receive all the information We requested.
3. If We fail to pay or deny a Clean Claim in accordance with item 1. above or give notice in accordance with item 2. above, We shall pay a penalty to the claimant for the period beginning on the sixty-first day after receipt of the Clean Claim and ending on the Clean Claim payment date (the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.
4. If We fail to pay or deny a claim in accordance with item 2. above which is not already subject to the penalty for the claim imposed by item 3. above, We shall pay a penalty to the claimant for the period beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period), calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.

“Clean Claim” means a claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by HIPAA, or on Our standard claim form with all required fields completed in accordance

with Our published claim filing requirements. A Clean Claim shall not include a claim: (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve one or more issues.

The following Sections are added:

CONSUMER INFORMATION NOTICE

The Insurance Company may be contacted at its Administrative Office:

Starr Indemnity & Liability Company
90 Park Avenue, 7th Floor
New York, NY 10016
212-230-5043
1-800-XXX-XXXX

The Insurance Agent may be contacted at:

[F.L. Dean & Associates, Inc.
1776 S. Naperville Rd., Bldg-B
P.O. Box 4200
Wheaton, IL. 60189
1-800-745-2409
FAX (630) 665-7294]

The State Insurance Department may be contacted at:

[Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904
1-800-282-9134]

GUARANTY ASSOCIATION NOTICE

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You

should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

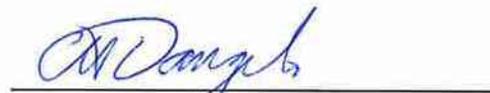
- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;

- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which benefits could be provided out of the assets of the impaired or insolvent insurer.


 [Honora M. Keane], General Counsel


 [Charles H. Dangelo], President

SERFF Tracking Number: MCHX-G127141061 State: Arkansas
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 48595
 Company Tracking Number: AH-20001
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: AH-20001 Blanket Accident - Starr Indemnity & Liab
 Project Name/Number: AH-20001 Blanket Accident - Starr Indemnity & Liability Company /AH-20001 Blanket Accident - Starr Indemnity & Liability Company

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>Attachments: SILC Blkt Acc - AR Readability Certification.PDF SILC AR Cert of Compliance 23-79-138 and RR 49.PDF SILC- AR Cert of Compliance Rule Reg 19.PDF</p>	Approved-Closed	04/27/2011
<p>Satisfied - Item: Application</p> <p>Comments: Application on form schedule.</p>	Approved-Closed	04/27/2011
<p>Satisfied - Item: Authorization Letter</p> <p>Attachment: 2011 SILC McHugh Filing Authorization.PDF</p>	Approved-Closed	04/27/2011
<p>Satisfied - Item: Explanation of Variables</p> <p>Attachment: Generic EOv AH-20001 .PDF</p>	Approved-Closed	04/27/2011

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Starr Indemnity & Liability Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
AH-20001	49.75
AH-20001 C	45
AH-20002	63
AH-20003	49.75
AH-20004	49.75
AH-20005-AR	46

Signed: 
Name: Honora M. Keane
Title: General Counsel

Date: 4/26/11

CERTIFICATE OF COMPLIANCE

Insurer: Starr Indemnity and Liability Company

Forms: AH-20001 et al

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Honora M. Keane

Name

General Counsel

Title

4/26/11

Date

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: Starr Indemnity and Liability Company

Forms:

AH-20001

AH-20001 C

AH-20002

AH-20003

AH-20004

AH-20004-AR

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Honora M. Keane

Name

General Counsel

Title

4/26/11

Date



Starr Indemnity & Liability Company

399 Park Avenue, 8th Floor,
New York, NY 10022

March 10, 2011

NAIC Company Code: 38318

Re: Attached Forms Listing

Please accept this letter as authorization from Starr Indemnity & Liability Company for McHugh Consulting Resources, Inc. to file any or all policy forms and/or rates as referenced in the corresponding SERFF filing on behalf of Starr Indemnity & Liability Company.

Sincerely,

Richard Thomas
Vice President

Starr Indemnity & Liability Company
Explanation of Variables
Blanket Accident Insurance Program

- All numbers (excluding form numbers) are variable. [Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.]
- The hazards will be included or excluded to suit the needs of the policyholder.
- The policy will either include the Full Excess or Primary provision.
- The Schedule of Benefits shall be considered as variable and will illustrate the policyholder's specific terms of coverage.

The Company reserves the right to amend the policy/rider forms to fix any minor typographical errors we may have neglected to find prior to submitting for approval.